The qualitative affordances of active and receptive music therapy techniques in major depressive disorder and schizophrenia-spectrum psychotic disorders

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Abstract

Background and objectives: Whilst Active and Receptive Music Therapy techniques have been widely researched and are employed within a range of contexts and with diverse client populations, this study reports on their specific qualitative musical and verbal affordances in major depressive disorder and schizophrenia-spectrum psychotic disorders. The study also describes and compares the respective and joint contributions of the music therapy techniques in giving rise to the affordances as well as reporting on the similarities and differences within and between diagnostic groups. This is the first study of its kind within the South African context.

Methods: A qualitative research approach using a case study design, sampled purposefully twenty patients of the above mentioned diagnostic groups for participation in this study comprising a course of eight twice weekly music therapy sessions. The primary data sources were transcribed video recordings of therapy sessions and an individual in-depth semi-structured interview after the course of therapy. Clinical session notes served as a corroborative data source. In-depth content and thematic analysis explored and compared qualitative affordances during music therapy comprising active and Receptive Music Therapy techniques. The qualitative affordances under investigation were i) musical qualities, and ii) verbal expressions. Emerging from these affordances were the respective and combined affordances of the music therapy techniques as well as the similarities and differences between the diagnostic groups.

Findings: Thirteen themes emerged from the analysis of clients' verbatim verbal responses to both active music making and Receptive Music Therapy techniques. These themes are: i) not to feel; ii) to do or not to do; iii) grappling with the desired future; iv) hurt and fear of undesirable outcomes; v) sadness, brokenness and futility; vi) anger, trust and vulnerability; vii) desire for connection with and affection of others; viii) barricaded from being present, now; ix) tensing and un-tensing; x) personal relating to one’s musical expression; xi) reflections on the music and music making in therapy; xii) resilience and courage and xiii) invigoration and liberation.

The Active Music Therapy techniques comprising clinical improvisation, structured musical exercises, drumming, vocal work, songwriting and movement, gave rise to ten themes expressing the musical affordances. The themes that emerged were i) reciprocal responding; ii) the explicit use of symbols through music; iii) regularity; iv) disturbance and difficulty; v) turning points; vi) energy bursting or lacking; vii) bodily synchrony; viii) intensified emotional expression; ix) exploring new territory and

x) resolution and arrival.

The emerging themes express the extent of musical and verbal expression of all clients representing both diagnostic groups. Most saliently among clients with depression the affordances were the themes on accessing creativity, accessing and articulating internal feelings, experiencing resilient parts of self, reflecting on and integrating symbolic material, motivation to act and extending musical and verbal expression during social interaction. Among clients suffering from schizophrenia spectrum disorder, the most striking affordances were experiences of regularity and flow within disorganization, orientation to 'here and now' experiences through active music making and working with symbolic material expressed on a continuum of concrete to abstract. Clients from both diagnostic groups experienced a reduction in unwanted symptoms as expressed through increased energy levels, experiences of pleasure in music making and spontaneous musical and verbal self-expression.

Conclusion: This study revealed qualitative affordances of specific music therapy techniques expressed through verbal content and musical qualities. These showed responses within a therapeutic relationship that express inter- and intra-personal connection, give voice to what is not always verbally accessible and facilitate multi-sensory, creative experiences, increased motivation, emotional expression, and the reclamation of energy, spontaneity and resilience.

Keywords: Active Music Therapy, Receptive Music Therapy, affordance, musical qualities, interpersonal interaction, verbal expression, symbolic material, imagery, major depressive disorder, psychosis, schizophrenia spectrum

Synopsis of the thesis

Chapter 1 – Introduction

Chapter 1 outlines the overall focus of the study as exploring the musical and verbal affordances of Active and Receptive Music Therapy techniques in the treatment for major depressive disorder and schizophrenia spectrum psychotic disorders. The chapter provides an overview of music therapy literature as it pertains to the respective diagnostic groups and situates the approaches of music therapy, and underpinning theories with reference to the music intervention designed for this study, within mental health and specifically for patients with major depressive disorder and schizophrenia spectrum psychotic disorders. This chapter further positions this research within the South African context characterised by the principles of African philosophies as expressed by Ubuntu and Batho Pele, which promote the values of both the individual and the communal, upholding person-centered care, diversity and relationship as core values in mental health care. Finally, Chapter 1 opts for blended music therapy as being suitable for this research, comprising active and receptive forms of music therapy supported by other creative arts modalities and verbal processing.

Chapter 2 – Research methodology

Chapter 2 presents the overall aim of this qualitative study that sought to explore, describe and compare qualitative affordances of a music therapy intervention comprising Active Music Therapy (AMT) and Receptive Music Therapy (RMT) techniques, respectively and in combination, among patients suffering from major depressive disorder and schizophrenia-spectrum psychotic disorders. The chapter describes the research paradigm, its case study design, purposive sampling and the inclusion and exclusion criteria pertaining to the two aforementioned diagnostic groups. The chapter further explains the various kinds of data collected during a course of eight twice-weekly sessions provided by the researcher-therapist, as well as the post therapy in-depth interview. The process of analysing the data guided by the principles of thematic analysis is described, detailing the steps of coding and stages of progressively higher order sorting and articulation of sub-themes and themes that emerged from the verbal and the musical expressions of participants. The last part of the chapter outlines ethical considerations and principles of trustworthiness salient to this study.

Chapter 3 – Findings: Verbal affordances

Chapter 3 presents the findings emerging from the verbal participation of clients in the music therapy sessions. Verbal responses were elicited during active musical participation, through music listening techniques and in the therapeutic conversation. The data analysis yielded thirteen themes pertaining to the verbatim verbal responses of participants. The themes were i) not to feel, ii) to do or not to do, iii) grappling with the desired future, iv) hurt and fear of undesirable outcomes, v) sadness, brokenness and futility, vi) anger, trust and vulnerability, vii) desire for connection with and affection of others, viii) barricaded from being present, now, ix) tensing and un-tensing, x) personal relating to one's musical expression, xi) reflections on the music and music making in therapy, xii) resilience and courage and xiii) invigoration and liberation.

These themes are illustrated by visual images, text, audio examples and direct verbatim quotes. Comparisons are made to differentiate among the contributions of the various music therapy techniques and between the diagnostic groups. The last part of chapter 3 presents the themes that were identified in the post therapy in-depth interviews. Even though the analysis of this was done independently by another researcher, similar themes emerged than did from within the sessions, thus corroborating the findings of affordances during therapy. These themes were i) praising the impact of music therapy; ii) gaining perspective; iii) being taken up within own experience; iv) creatively inspired and energized for the future; v) coming to joy and peace; vi) liberation to do, and from frustration; vii) upbuilding and filling; viii) closer and improved interaction; ix) opening up and emotionally dealing with old wounds; x) grappling with or to change; xi) strengthening more than expected and xii) unease in and before therapy.

Chapter 4 – Findings: Musical affordances

Chapter 4 presents the second set of findings that express the musical affordances within the music therapy sessions. The musical affordances refer to the Active Music Therapy component of the music therapy intervention that comprised structured music-centered exercises and improvised music making in the form of instrumental improvisation, drumming, movement and singing. The musical affordances were described in terms of the clients' individual musical participation as well as conjoint musical interaction between client and therapist with reference to the musical qualities of rhythm, dynamics, tempo, phrasing and pitch. These descriptions were independently verified from audio-video recordings. The themes that emerged were i) reciprocal responding; ii) explicit use of symbols

through music, iii) regularity, iv) disturbing and difficulty, v) turning points, vi) energy bursting or lacking, vii) bodily synchrony, viii) intensified emotional expression, ix) exploring new territory and x) resolution and arrival. Video examples and visual images are used to illustrate the descriptions of musical qualities and the themes they expressed. Comparisons are made to differentiate between the diagnostic groups with regard to participation in active music making.

Chapter 5 – Appraisal of the study

Chapter 5 appraises the findings and the research methods from which they derive. The appraisal of findings highlights how the three sets of emerging themes yield interpretatively eleven salient aspects, articulated as 'emerging voices'. These voices express i) struggle; ii) disturbance; iii) feeling feelings; iv) desire; v) isolation; vi) powerlessness; vii) flow and connection; viii) reflecting; ix) symbolism; x) resilience and xi) liberation.

The respective music therapy techniques and diagnostic group verbal and musical responses gave rise to the three sets of themes as detailed in chapters 3 and 4 and emerging voices as highlighted above. The contribution of Receptive Music Therapy, identified interpretatively expressing similarity across themes, is articulated through the following: i) eliciting and voicing internal feeling states; ii) telling of personal story; iii) self as social being; iv) self- awareness; v) desire; vi) increased internal motivation and vii) activation to action. Active Music Therapy enabled i) appropriation of music for personal expression; ii) embodiment; iii) being active; iv) calling to focus; v) agency; vi) relationship; vii) spontaneity and creativity; viii) recreation and ix) stress release. The joint contributions of the music therapy techniques, expressed in the following subheadings, were interpretatively identified as i) revealing impasse and difficulty; ii) unconscious material and different aspects of self; iii) heightened experience of the music; iv) the language of symbol and metaphor; v) shifts; vi) inner strengthening; vii) experiencing vitality and viii) relaxation and calming.

Within and between comparisons of the diagnostic groups yielded three primary differences through an interpretative synthesis of the themes in virtue of similarities and differences across the comparative findings i) clients with depression could more readily access emotions and articulate specific feeling states whereas clients with schizophrenia experienced difficulty accessing and naming feelings; ii) clients with depression were able to more readily reflect on the words, music and symbols within the music therapy process from session to session, as well as over time, whereas the clients in the Schizophrenia Spectrum group worked more in the immediacy of the moment through verbal and

musical expression and iii) clients with depression seemed more able to articulate specific desires or actions towards envisaging a future or recovery (even when this seemed remote or hard to attain in the face of difficulty), whereas clients with schizophrenia seemed to articulate aspirations disconnected from a sense of practical application to concrete, daily life.

Clients from both diagnostic groups experienced heightened energy levels, articulated experiences of pleasure in music making and engaged in spontaneous musical and verbal self-expression, reflecting experiences of liberation, creativity, shifts and personal benefit to a greater or lesser extent.

The affordances are further reflected upon in terms of implications for practice considering the therapeutic potential within the interdependence of Active and Receptive Music Therapy techniques. Critique of the research included reflection upon sample size, the selection of one public mental health context as the site for the research, the duration of the music therapy intervention and data saturation with reference to the extent of data generated by the study. The research is the first larger study of its kind in a public mental health facility in the South African context. The findings from the research contribute to the literature with its emphases on individual therapy, the blended music therapy approach, an in-depth analysis of verbal as well as musical responses and the specific focus on the music therapy intervention with the specific diagnostic groups identified for the study.

The chapter makes recommendations for further research serving to extend and further elaborate upon the findings of this research. Such research would include extending the research to additional clinical sites in both the public and private health sector, further in-depth qualitative analysis of specific music therapy techniques and diagnostic group response, extending such research to include other diagnostic groups and, finally, broadening the focus of the current research to include group music therapy.

Whilst the findings of this study should not be generalised to the general population, the clinical techniques and emerging affordances may be applicable or transferable to other comparable contexts.

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List of Abbreviations

GIM	Guided Imagery and Music
EBT	Evidence Based Treatment
CMT	Creative Music Therapy
BMGIM	Guided Imagery and Music – The Bonny Method
CBT	Cognitive Behavioural Therapy
PANNS	Positive and Negative Symptom Scale
BNSS	Brief Negative Symptom Scale
AMT	Active Music Therapy
RMT	Receptive Music Therapy
BMT	Behavioural Music Therapy (BMT)
AOM	Analytically Oriented Music Therapy
MIRS	Musical Interaction Rating Scales
LSD	Lysergic acid diethylamide
GMI	Guided Music Imagery
UMI	Unguided Music Imaging
DMI	Directed Music Imaging
GrpMI	Group Music and Imagery

MDN	Music, drawing and narrative
IPA	Interpretative Phenomenological Analysis
MDD	Major Depression Diagnostic Group
SS	Schizophrenia Spectrum Diagnostic Group
DVD	Digital Versatile Disc
VA	Codes pertaining to verbal responses to Active Music Therapy
VR	Codes pertaining to verbal responses to Receptive Music Therapy
AM	Codes pertaining to active music making
VAT	Verbal affordances themes
MAT	Musical affordances themes
IntT	In-depth interview themes
EPICURE	Acronym used for evaluation of research: Engagement, Processing, Interpretation, Critique, Usefulness, Relevance, Ethics

Chapter 1: Introduction

1.1. Introduction

This research study explores the musical and verbal affordances of Active and Receptive Music Therapy techniques in the treatment for major depressive disorder and schizophrenia-spectrum psychotic disorders. This introductory chapter outlines a framework for this thesis by providing an overview of music therapy literature as it pertains to the respective diagnostic groups, discussing the psychotherapeutic approaches informing the music therapy intervention and presenting the premises of the music therapy approaches central to this research.

Whilst music therapy research internationally has given rise to a body of literature in which the role of music therapy in psychiatry has been investigated and documented, no work of the nature done here has been researched in the South African context. Foundational work in the earlier years by, inter alia, Pavlicivec (1991) and Wigram and De Backer (1999) paved the way for music therapy in adult mental health to evolve through developing and adapting a range of Active and Receptive Music Therapy techniques to meet the diversity of client needs and make music therapy more accessible to service users (Cassity, 2006; Codding, 2002; Gold et al, 2009; Grocke and Wigram (2007), Rolvsjord, 2005; Silverman, 2007; Unkefer and Thaut, 2005).

Neither outside South Africa, have the specific musical and verbal affordances between specific music therapy techniques and the diagnostic groups of major depressive disorder and schizophrenia-spectrum psychotic disorders been researched before. A taxonomy of programs and interventions that link music therapy techniques to diagnostic groups for mental health disorders has been developed by Unkefer and Thaut (2005). This taxonomy includes six categories of techniques: i) music performing that includes vocal and instrumental improvisation and performance techniques, ii) music psychotherapy, iii) music and movement, iv) music combined with other expressive arts, v) recreational music and vi) music and relaxation. The taxonomy details diagnostic symptoms, clinical features, characteristic behaviours, needs, music therapy interventions, programs and techniques for the following mental health disorders: i) schizophrenic disorders, ii) bipolar disorder depressed episode and iii) bipolar disorder, manic episode and iv) generalised anxiety disorder (Unkefer and Thaut, 2005: 185).

Silverman (2007) conducted a survey through the American Music Therapy Association to evaluate psychiatric music therapists and their approaches, institutions, interventions and clinical objectives. Most respondents indicated that they worked with music therapy groups rather than individual clients. The majority of respondents indicated that their orientation is eclectic and, in terms of techniques employed, most stated that they used improvisation, sing-alongs, lyric analysis, and music-assisted relaxation addressing goals such as socialization, communication, self-esteem, coping skills and stress reduction/management. The least number of participants indicated that they used Guided Imagery and Music (GIM) and movement (see below for descriptions of these music therapy techniques). However, they did not explore in their study which approaches and techniques were most suitable for different diagnostic groups.

In a study by Gold et al. (2009) a meta-analysis of the effects of music therapy for patients with serious mental disorders, the findings suggest music therapy's efficacy for three negative symptoms which could be shown as trans-diagnostic phenomena. They suggest that music therapy is a) a medium for emotional expression which may help patients improve their expressive range and thus diminish affective flattening; b) making music together is always a social act thus assisting patients with deficits in this area, primarily calling them from social withdrawal and isolation and c) participation in music can serve as a motivating factor for patients with low levels of motivation.

This meta-analysis showed that when music therapy is added to standard care, it has "strong and significant effects on global state, level of general symptoms, negative symptoms, depression, anxiety, functioning and musical engagement" (Gold et al., 2009: 203). The study further showed that the effects of music therapy do not depend on diagnosis, neither on study design. Effect seemed mainly dependent on the number of sessions provided.

Gold et al. (2009), in observing that there appears to be no direct link between technique and diagnosis, acknowledge that limited research has been conducted in this area. Hence, this study compared patient response to music therapy techniques across the two - diagnostic groups, viz. major depressive disorder and schizophrenia-spectrum psychotic disorders. This research also compared the affordances of the music therapy techniques respectively and in combination. These comparisons will be used for developing a conceptual framework that expresses the applicability of techniques to each of the diagnostic groups.

Whilst the treatment plan for a client or group should be structured around the individual's/group's needs, and diagnosis is one of a number of considerations, a more substantial evidence-based understanding of the best fit of technique with diagnosis could enhance the efficacy of such interventions.

Silverman (2010) refers to Evidence Based Treatment (EBT) in the fields of psychiatry and psychology specifically relevant to the United States of America. The six EBTs are i) Assertive community practice, ii) integrated dual-disorder treatment, iii) family psychoeducation, iv) illness management and recovery, v) medication management and vi) supported employment. Silverman (2013) discusses music therapy practice within the context of EBT as a means to challenge and focus the contribution of music therapy in the field of mental health. Whilst the primary work of music therapy services does not fall within all the EBTs mentioned, the challenge is for music therapists to work creatively and proactively within institutional and national protocols of mental health care and treatment in order for music therapy practice to remain relevant and valued.

In addition, Silverman (2013) highlights the changing culture of the mental health system in the United States which sees patient length of stay reduced significantly, resulting in treatment programs designed for acute rather than chronic settings . He cites Thomas (2007) who, in the light of this, challenges music therapists to rethink and redevelop models of treatment. Whilst this refers specifically to incorporating psychoeducation in clinical interventions in order to enhance patient coping and maintenance skills, it is a broader call to conceptualise shorter term music therapy interventions that are as effectual as possible within the changing face of mental health care systems.

This changing reality equally applies to the South African context. When I first began working and supervising interns at Weskoppies Psychiatric Hospital in 2004, the norm was that patients who attended music therapy sessions were long term patients, residing in chronic treatment wards, most likely to remain in hospital for an indefinite, if not permanent period. That has significantly changed. In fact, some patients referred to this research study were not in hospital long enough to attend all eight music therapy sessions.

Lund et al. (2012) refer to the burden of mental illness in South Africa as substantial, with mental disorders ranking third in their contribution of disease to the country. In 2012 it was estimated that 1 in

6 individuals were likely to experience a common mental disorder. They highlight the relationship between physical and mental health as being well established, and in the South African context, particularly with respect to, but not exclusively, HIV/AIDS. According to Lund et al. (2012) 75% of people living with mental disorders do not receive the care they need. Human rights of the patient is at the heart of the impetus to improve mental health services calling for the "need to develop evidence-based and culturally appropriate mental health services that can feasibly be delivered within available resource constraints and integrated with other health services (Lund et al., 2012: 402).

Institutional and national protocol and requirements in terms of evidence based treatment and practice may differ from context to context, it is, nonetheless, critical that music therapists within the South African context engage with mental health care services based on documented evidence which is relevant and cost effective in order to contribute to multi–disciplinary therapeutic offerings in adult mental health settings.

Wigram et al. (2002) made the point that, in the field of psychiatry during that period, Active Music Therapy was primarily the most widely used method. Increasingly, the emergence of a broader range of techniques drawing from active and receptive forms of music therapy are included in mental health settings (Grocke and Wigram, 2007; Unkefer and Thaut, 2005).

As researcher, my training in Creative Music Therapy (CMT), an Active Music Therapy approach as well as in Guided Imagery and Music –The Bonny Method (BMGIM), a Receptive Music Therapy method, qualifies me to conduct this study that is designed to incorporate combining different forms of music therapy. In my clinical work, I have developed music therapy techniques based on the principles of GIM and CMT in which music and other creative modalities, such as drawing, movement and clay work are combined. I have observed, using these techniques, that whilst music and other creative modalities have the capacity to contain and give expression to difficult emotional/psychological/spiritual and relational material, they also tap into innately creative aspects of human capacity and potential, thus serving as strength-building resources. This approach to therapy, employing creative, music-centred therapeutic interventions, has the potential to build and nurture resilience and enhance wellbeing for patients who often experience fragmentation and isolation at numerous levels (Rolvsjord, 2005).

Music therapists in South Africa are increasingly employing diverse techniques in the field of psychiatry within a range of private as well as public and community mental health settings. Not much work emanating from the South African context, though, has been documented. It is, thus, crucial that music therapy in these settings be investigated and published. It is important, also, to consider the response of specific diagnostic groups as well as the contribution of different music therapy techniques.

This research study, thus, aimed to investigate the affordances of Active and Receptive Music Therapy respectively and in combination, specifically within the field of psychiatry, focusing on persons suffering from major depressive disorder and schizophrenia-spectrum psychotic disorders respectively.

Whilst the focus of this research is on present moment affordances of music therapy techniques as expressed through the verbal and musical participation of the client, it is hoped that the 8-week blended music therapy intervention might contribute to an emerging body of evidence applicable to adult mental health in the South African context.

1.2. The patient groups

The patient groups identified for the purposes of this study are major depressive disorder and schizophrenia-spectrum psychotic disorders respectively.

1.2.1. Major depressive disorder

This disorder presents with one or more major depressive episodes, each of at least 2 week duration with significant affliction for at least most part of just about every day. The depressive episode causes clinically significant distress and/or impairment in occupational, social and other important areas of functioning. It presents with a constellation of the following symptoms: depressed mood for at least 2 week duration for most of the time; markedly diminished interest or pleasure in all or almost all activities most of the time; observable psychomotor retardation or agitation; fatigue or lack of energy most of the time; excessive feelings of worthlessness or excessive guilt most of the time; sleep disturbance; diminished ability to think, concentrate or indecisiveness most of the time; appetite disturbance (with or without weight change), recurrent thoughts of death, and/or suicide with or without plans and attempts (American Psychiatric Association, 2013)

Both pharmacotherapy and psychosocial interventions are proven efficacious interventions, usually used in combination. Pharmacotherapy is not necessarily required for episodes of mild to moderate degree, whereas psychosocial interventions may not be feasible for episodes of a severe degree. Music therapy is considered a psycho-social intervention among various kinds of psychotherapies used for this disorder. Music therapy may be used inter alia to affect the patient's mood, engage the patient emotionally, engage the patient interpersonally, and bring about change in interpersonal patterns of behaving, thinking and feeling,

1.2.2. Schizophrenia-spectrum psychotic disorders

These disorders share various combinations and kinds of symptoms, being delusions, psychotic hallucinations, severely disorganised thoughts, catatonia, and symptoms of affective blunting, avolition, and anhedonia.

DSM-5 (American Psychiatric Association, 2013) lists the following disorders in this category, viz. schizotypal disorder, delusional disorder, brief psychotic disorder, schizophreniform disorder, schizophrenia, schizoaffective disorder substance/medication-induced psychotic disorder, psychotic disorder due to another medical condition, catatonia associated with another mental disorder, catatonic disorder due to another medical condition, unspecified catatonia, other specified schizophrenia-spectrum and other psychotic disorder, and unspecified schizophrenia-spectrum and other psychotic disorder.

Pharmacotherapy is usually the mainstay of treatment, with psycho-social interventions playing a significant augmentative role. Most patients usually benefit from both kinds of interventions, with music therapy as a psycho-social intervention contributing in the ways described above.

1.3. Music therapy studies in depression

The Cochrane review on music therapy and depression by Maratos et al. (2009) found five studies that met the inclusion criteria for the review. Four studies (Chen, 1992; Hanser, 1994; Hendricks, 1999; Radulovic et al., 1997) reported clinically significant positive effects and one (Zerhusen1995) in which music therapy was used as a control treatment, showed no effect.

These studies reflect group music therapy processes and music therapy interventions included guided imagery to prescribed music, joint music making between client and therapist. It is noted that amongst a range of qualitative studies Receptive Music Therapy was 'prescribed' for the alteration of mood states. The review highlights the range of music therapy interventions which included primarily Receptive Music Therapy techniques such as guided imagery to music, 'prescribed' music to induce particular emotional states, for example relaxation or motivation; reflective discussions based on pre-composed music chosen by the patient or therapist. To a lesser extent joint music making between therapist and participant(s) was used. Only one of the studies examined the effects of an Active Music Therapy approach (Chen 1992).

Two studies, Hendricks et al. (1999) and Zerhusen et al. (1995), compared group music therapy with group cognitive therapy, where music therapy was used as the active control treatment. This revealed varying outcomes. The CBT lasted 90 minutes and involved no more than seven participants, whereas the music therapy group ran for 60 minutes and involved 20 people. CBT was structured and had a coherent theoretical approach; whereas the group music therapy appears to not have been as structured nor framed within a specific theoretical paradigm. The conclusion was drawn that, without a coherent therapeutic framework and understanding, listening to music alone within a large group, even with a trained therapist, is not effective. The findings from Chen (1992) indicate that large group music therapy treatment can be effective when there is a coherent therapeutic strategy behind the use of music. Hanser (1994) shows that music therapy can be effective, when combined with CBT homework exercises. It was found that this may be more cost effective than large group work, if the patient is well briefed for the home-based intervention.

Overall the reporting of studies was deemed poor with respect to randomisation procedures which were partial or absent and the interpretation of study findings was limited due to lack of data on variance of study outcomes. It was, nonetheless found that levels of uptake and participation in music therapy appear to be high, with the drop-outs rate low, and the majority of participants completing treatment. Given the difficulties of living with depression and yet sustaining active involvement in treatment, might indicate the efficacy of music therapy as an intervention. Furthermore, most of the studies included in the review showed positive effects in reducing depressive symptoms, indicating that further research in this area is recommended (Maratos et al., 2009).

Choi et al. (2008) conducted a study in South Korea, which found that music therapy significantly improved psychiatric inpatients' depression, anxiety, and relationships. (Choi, Lee, & Lim, 2008) and in a more recent study by Silverman (2013) it was found that group psychoeducational songwriting increased quality of life with psychiatric inpatients suffering from depression.

Garrido et al. (2017) conducted a study on group rumination and the effects of group music listening on people with depression. It was found that people with depression were more likely to engage in group rumination using music. The study sought to clarify under which condition music listening in a group setting would provide social benefits and which would amplify negative emotions. Whilst this research study focuses on individual and not group music therapy it is important to consider when music may intensify rumination rather than offer supportive, cathartic experiences.

The Cochrane review by Maratos et al., (2009) identified two gaps in the literature with regard to music therapy as an intervention for depression i.e. the studies reviewed suggest, firstly, that Receptive Music Therapy is the primary modality used for the treatment of depression and that, secondly, It was highlighted that the review dealt primarily with studies concerning the elderly and adolescents and that the middle years age group was not accounted for substantially. Only one study was reviewed which dealt with a younger age group (Radulovic et al., 1997). A subsequent study conducted by Erkkilä et al. (2011) employed an improvisational, psychodynamic music therapy intervention with working age individuals. The results indicated that those receiving music therapy plus standard care improved with regard to general functioning as well as with respect to depression and anxiety symptoms compared to those who received standard care only.

This study addresses both of these gaps through i) employing a blended music therapy approach comprising a range of active and receptive forms of music therapy with participants from the aforementioned diagnostic groups and ii) whilst no restriction was placed on age for participation in the study, the age range of participants was 18-57 years.

1.4. Music therapy studies in schizophrenia

Two Cochrane reviews concerning music therapy for schizophrenia have been published (Gold, Heldal, Dahle, & Wigram, 2005; Mössler, Chen, Heldal, & Gold, 2011). In both reviews, all studies were

examined in respect of the effects of music therapy as a complementary treatment to standard care. In sum, the results of the first Cochrane review (Gold, et al., 2005), which included only 4 studies, suggested that music therapy improves global state and may also improve mental state and life functioning, especially the negative symptoms, if a sufficient number of music therapy sessions are provided.

Results of the second review (Mössler et al., 2011) that included 8 studies with a total of 418 participants suggest that at least 20 sessions may be needed to obtain clinically significant results. This concurs with the dose-effect relationships found in Gold, Solli, Krüger, & Lie (2009) which indicated a relationship between less effect of music therapy after 3-10 sessions and greater effect after 16-51 sessions. Mössler et al. (2011) suggest that music therapy seems to address especially motivational, emotional and relational aspects, and helps patients reconnect to both intrapersonal and social resources. Session dosage is emphasised as a benefit, as well as the quality of therapy as conducted by a trained therapist. Participants do not need musical skills, but a motivation to work actively within a music therapy process is important (Mossler et al., 2011:23). The review further concludes that "Music therapy may be especially important for improving negative symptoms such as affective flattening and blunting, poor social relationships, and a general loss of interest and motivation. These symptoms seem to be specifically related to music therapy's strengths, but do not typically respond well to other treatment" (Mössler, et al., 2011, p. 23). Further studies investigating the effect of music therapy on negative symptoms include a study by Talwar et al. (2006) where it was found that music therapy improved negative symptoms compared to standard care alone, a study by Tang et al. (1994) who investigated the rehabilitative effect of music therapy for residual schizophrenia. This was a randomised control conducted in Shanghai for a month where seventy-six in-patients who had the residual subtype of schizophrenia were randomly assigned to a treatment group or a control group. Both groups received standard medication as prescribed by their treating physicians, but the treatment group also received a one-month course of music therapy that included both passive listening to music and active participation in the singing of popular songs with other patients. It was found that music therapy reduced negative symptoms and social isolation and helped increase interest in the external environment and resulted in increased levels of social interaction. Pavlicevic, Trevarthen & Duncan (1994) found that music therapy improved negative symptoms, as seen through how musical participation significantly raises the time the patient suffering from schizophrenia takes part in musical interaction compared to the control group. Another study conducted by Hayashi et al. (2002) showed

improved motivation, less passivity and a better ability for communication as a result of music therapy and a study by de l'Etoile (2002) indicated that music therapy positively impacts cognition and emotion. Pedersen (2016) is leading a current, as yet unpublished research study, at the Music Therapy Research Clinic at Aalborg University Hospital's Center for Schizophrenia. The study is interdisciplinary and involves both music therapists and medical doctors who specialise in schizophrenia, focusing on music therapy as a treatment for negative symptoms, using a control group. The study also includes a controlled rating procedure using PANNS (Positive and Negative Symptom Scale) and BNSS (Brief Negative Symptom Scale). 120 participants from all regions in Denmark will participate in the study. This is towards advocacy supported by evidenced based practice. Music therapy is recommended as a part of standard care for people suffering from schizophrenia in national guidelines of Norway, Sweden and the U.K., but not in Denmark. It is thus envisaged that the results of this study will strengthen the evidence for music therapy as an intervention for schizophrenia and pave the way for the inclusion of music therapy as part of standard treatment in Denmark (Pedersen, 2016: 14).

Bloch et al. (2010) conducted a study to examine the effects of music relaxation on sleep quality and emotional measures for clients diagnosed with schizophrenia. The findings indicate that playing music every night for a week induced relaxation indicated benefit for insomnia and emotional measures with regard to depression and anxiety for people living with schizophrenia.

In a study by Grocke et al. (2013) the aim was to determine whether group music therapy, and in particular group singing and songwriting, positively impacted quality of life, social enrichment, self-esteem, spirituality and psychiatric symptoms of participants with severe mental illness (Grocke et al, 2013: 144). Themes emerging from this study included i) motivation, encouragement and hope, ii) being alone/isolated, lost, iii) appreciation of positive relationships, iv) dreaming and imagining the future, v) instructions and advice to self and others, vi) longing, vii) leaving and changing and viii) descriptions of nature reflecting hope (Grocke et al, 2013: 151). The significant outcomes of the study indicate that quality of life and self-esteem improved, that group music therapy created opportunities for fostering social connections and that music therapy should be considered as a component of holistic care in mental health (Grocke et al, 2013:144).

1.5. Theoretical underpinnings of music therapy as intervention

Music therapy approaches are theoretically informed by, inter alia, musicology, ethno-musicology, psychology, music psychology, sociology, medical, educational and anthropological discourses (Ansdell, 1995; Pavlicevic, 1997; Wigram 2002). Numerous theoretical paradigms govern a variety of models of music therapy practice, which can be categorised within two overarching approaches, namely Active Music Therapy (AMT) and Receptive Music Therapy (RMT). These umbrella approaches and their associated models and techniques approach music therapy practice from distinct perspectives in terms of a) theoretical framework, b) practical clinical application, c) how music is conceptualised as a therapeutic tool and d) affordance and benefit for clients. For this reason some approaches are more suitable than others for certain client groups and certain techniques are more appropriate for specific clinical goals.

The music therapy intervention employed in this study, was specifically designed for individual music therapy. It is a blended music therapy intervention comprising Active and Receptive Music Therapy techniques used separately and in combination. These techniques include the use of other modalities such as movement, drawing and clay work. The focus of investigation is both the musical and verbal expression of participants within music therapy session.

The music therapy intervention was informed by the following psychotherapy and mental health care approaches: i) humanistic, ii) psychodynamic, iii) resource-oriented music therapy and iv) Ubuntu being an African orientation.

The humanistic approach recognises the need of every person to strive towards growth and wholeness. The approach emphasises the centrality of the client within the therapy space. Rogers (1951) referred to empathy, unconditional positive regard and congruence as features of this approach in facilitating self - actualization in clients. “The therapist's role is to be immediately accessible to the client and to focus on the here-and-now experiences created in the therapeutic relationship. A respectful, attentive, caring, and understanding attitude will assist the client in breaking down barriers and achieving more satisfying levels of personal functioning” (Scovel and Gardstrom, 2012).

The psychodynamic approach recognises that the psyche functions as a result of both conscious and unconscious processes. The work of therapy is to bring to consciousness unresolved conflicts or unconscious material that may be a hindrance to personal growth (Jung, 1997). Akin to free association in verbal psychotherapy, is clinical improvisation in music therapy. Clinical improvisation can elicit repressed feelings, can bring to light transference and counter-transference dynamics present in the therapeutic relationship as well as be a sonic representation of unresolved conflicts and resistance (Priestley, 1994). Through music listening techniques imagery and symbolic work illuminate unconscious processes, which once externalised through verbal processing and the inclusion of visual art process can assist clients to consciously address areas of impasse (Bonny, 2002; Jung, 1997).

Resource-oriented music therapy upholds the following principles: i) nurturing of strengths, resources and potentials, ii) collaboration rather intervention, iii) views the individual within their context, and iv) music is seen as a health resource (Rolvsjord, 2010: 74-83). The term 'intervention', synonymous with the medical model, is replaced by collaborations, negotiations and interactions which characterise the relational exchange between client and therapist (Rolvsjord, 2010; 23). This approach is connected to an empowerment philosophy and focuses on "amplifying strengths rather than mending weaknesses of clients, recognizing competencies related to their therapeutic process of change, nurturing and developing resources of clients through musical interactions and collaborations in the therapeutic process and focusing on musical resources and music as a resource" (Rolvsjord, 2005: 99).

With this study being situated in South Africa, an African perspective on mental health applies in doing music therapy. This perspective is closely aligned to humanistic and resource-oriented approaches, in particular expressing the principle of Ubuntu. Ubuntu is an isiZulu term, originating in Southern Africa, denoting a common social orientation in Sub-Saharan Africa. It is aptly expressed in the isiZulu phrase "Umuntu Ngumuntu Ngabantu" which means in part: "we are people because of other people", embodying the African notion of humaneness (Wilson and Williams, 2013: 82). Ubuntu places emphasis on the notion that we are human because of others. The communal, or extended family is of central importance. Ubuntu postulates that there is no I without the 'we' and "recognizes the humanity in us all, discovering ourselves, resolving our own human differences through our interactions with each other" (Wilson and Williams, 2013: 82) This approach to mental health holds that well-being is linked to the self as a social being rooted in familial, communal and cultural contexts, and refers to the three C's model of mental health: connectedness, competency and consciousness (Wilson and Williams, 2013:

84). The three C's model regards wellness as being determined by connectedness rather than individuation, social competency rather than competency from self and social or communal consciousness rather than personal consciousness. This model emphasises the integral role of community and the social self as a resource for wellness, it values unity, and promotes the qualities of selflessness and consideration for others.

Akin to the notion of Ubuntu is the Sesotho expression 'batho pele' which means 'people first'. This advocates for an African version of values-based mental health care that is person-centred, respects diversity and champions both the individual and society as important in decision making and ethical deliberation (van Staden, 2011:15). In its respect for the humanity of the service user, this approach advocates for co-production, peer-supported recovery, interdependence and making space for the voice of the client. (Crepaz-Keay et al., 2015).

The blended music therapy intervention used in this study draws on three primary music therapy approaches: i) Creative Music Therapy with the primary focus being on the centrality of the music through active music making between client and therapist enabling therapeutic work to take place and, where needs be, at a purely non- verbal level (Nordoff and Robbins, 1977), ii) Guided Imagery and Music (The Bonny Method) places the emphasis on music listening, verbal reflection and visual art processes through which imagery, emotions and associations elicited by the music are processed (Bonny, 2002) and iii) Analytically Oriented Music Therapy which brings together the use of active music making and verbal processing. Clients are involved in verbal interaction with the therapist in terms of planning and playing improvisations, as well the reflection thereon.

Reference to further literature regarding music therapy in psychiatry will be made in the following discussion which provides an overview of the primary models of music therapy relevant to this research i.e. Creative Music Therapy, Behavioural Music Therapy, GIM and Analytically Oriented Music Therapy.

1.5.1. Active Music Therapy

Active Music Therapy refers to therapy in which client and therapist actively engage in music making together in the form of clinical music improvisation and musical exercises with the view to eliciting alternative forms of communication, self - expression and behaviour modification. Three primary

models associated with Active Music Therapy are Creative Music Therapy, Behavioural Music Therapy and Analytically Oriented Music Therapy and these will be discussed briefly as they emphasise different aspects of music therapy work in the field of mental health.

1.5.1.1. Creative Music Therapy

Creative music therapy, otherwise known as improvisational music therapy is a music- centred approach developed in the 1970s by Paul Nordoff, an American composer and pianist and Clive Robbins, a British special needs educator. Creative Music Therapy has as its departure point the innate capacity for each person to communicate in a musical way. "This innate musicality, often subsumed by the emergence, and eventual primacy, of words is tapped in music therapy, precisely because its essential nature is emotional" (Pavlicevic, 1997:118). The clinical use of improvisation enables those limited in verbal and cognitive capacity, and thus often intra-personally and socially isolated, to draw upon alternate means of communication and self-expression. Referring to Nordoff and Robbins (1977), Pavlicevic (1997) speaks of the 'music child'. "Music therapy improvisation addresses the music child by inviting the person to express him or herself through sounds and by reading the child/adults capacity for flexibility in organising rhythm, melody, tempo as portraying the person's expressive and communicative, reciprocal capacities" (Pavlicevic, 1997:118). Ansdell (1995) identifies specific processes in clinical improvisation which details how music works in creative music therapy.

1.5.1.1.1. Musical interaction

Ansdell (1995) draws from Martin Buber in his work on the nature of dialogue. Applying this to Improvisational Music Therapy the therapeutic relationship and process begins with client and therapist being very distinctly 'I' and 'You'. The goal is to move from "I"/'You" to "We" – a shared encounter where there is a flow of musical interaction, a meeting in the music. This takes place when the therapist matches the music of the client and allows the client to hear and experience him/herself in relation to the therapist. This could take many sessions to arrive at this point and there is no formula attached to this process. Intrinsic to this process is the client being heard and experiencing themselves in the music and in relation to another.

The effectiveness of music therapy derives from the potential of music to move us both emotionally and physically. Our human bodies are organised in terms of rhythm, pulse and cycles. What is important to understand about many clients is that the rhythm, phrasing and pulse of their bodies is altered through pathology. It is the basic elements of music, rhythm, melody and phrasing which help to give back to the client what was lost or weakened. Here the inherent structure of music facilitates concrete, structured experiences where e.g. patients presenting with disorganised thought and speech are potentially afforded a structured musical experience, enabling moments of intra and inter-personal interaction and regulation in the 'here and now' (Ansdell, 1995:13).

1.5.1.1.2. Play, primary creativity and improvisation

The embodied nature of the creative musical experience in the context of the client therapist relationship is congruent with Winnicott's (1971) theory of interpersonal development which postulates the concept of 'primary creativity'. From birth humans begin creating their world. This innate capacity for creating includes spontaneous play and imagination. Primary creativity is not confined to infancy but is part of life for the duration of one's life. Winnicott's (1971) theory of play included thinking about the transitional space in and through which the infant is contained by the primary caregiver, thus afforded the space to explore (improvise) their world towards differentiation from the parent figure. This understanding of play and primary creativity is a useful analogy for extending our understanding of clinical improvisation in music therapy. Pavlicevic (1997) captures this aptly by stating "when a music therapist and patient are able to create a shared musical space between them, then an intimate and dynamic inter-subjective relationship is possible" (Pavlicevic, 1997:150-151).

Ruud (1998) who talks about improvisation as play and fantasy, says that through play we enter into dialogue with outside reality, role play and change it symbolically. In clinical improvisation to use music metaphorically as representing an external reality can assist the client to face and deal with that reality within the context of a supportive relationship and being known in their musical metaphor.

1.5.1.1.3. Listening

The importance of listening in clinical improvisation cannot be emphasised enough. For the therapist, listening to the person and music of the client is perhaps more important than playing. Clinical

Improvisation implies a new way of listening where all that has been discussed thus far is brought together through the act of listening. The therapist tunes into the non-verbal cues provided by the client, listens to the emotional and musical rhythm of the client in order to respond. This in turn will invite the client to listen in a new way, to themselves, as well as to the therapist within the personal-musical relationship (Ansdell, 1995; Pavlicevic, 1997).

1.5.1.1.4. Music as non-verbal expression

Creative Music Therapy does not place primary emphasis on verbal processes. The therapeutic work happens within the music. Because of this, clients who have limited verbal capacity are not excluded from potentially meaningful therapy processes. Clients are drawn into a music-therapeutic relationship inviting them to bring who they are through their music into the therapy space. Music allows for the expression of unmanageable and silenced unconscious material as well as what is innately creative, resilient and healthy (Ansdell, 1995; Priestly, 1994). Across all approaches within music therapy, music is regarded as a strengths-based resource where the focus shifts from pathology alone, to eliciting inner resilience and building capacity for intra and interpersonal communication. Solli (2008) in his work with a patient suffering from schizophrenia comments on how the improvisational use of the musical preference of a patient can afford possibilities of strengthening weakened self-awareness and facilitating meaningful relational development thus drawing the patient out of isolation. He emphasises the role that the structural elements of music plays in providing concrete, 'in the present moment' experiences for the patient.

1.5.2. Behavioural Music Therapy (BMT)

The focus of Behavioural Music Therapy is on the concrete use of music for the purposes of behavior modification, including physiological, motor, psychological, emotional, cognitive, perceptual and autonomic behavior. BMT can address a variety of non-musical goals such as social engagement, physical activity, communication, cognitive processes, attention and concentration, enjoyment, reduction and elimination of antisocial behavior and independence skills (Wigram et al, 2002 : 134-135; Lotter, 2011). Wigram et al. (2002) refer to Bruscia's (1998) definition of BMT as "the use of music as a contingent reinforcement or stimulus cue to increase or modify adaptive behaviors and extinguish maladaptive behaviors" (Wigram et al, 2002:134). Madsen and Cutter (1966), the forebears of

Behavioural Music Therapy identify four ways in which music is used as treatment in BMT: a) as a cue, b) as a time structure and body movement structure, c) as a focus of attention and d) as a reward. In BMT music can be regarded as a stimulus and organiser of non-musical behaviour. It can involve teaching a client a musical skill, the use of music listening or improvisation. The primary focus of BMT is to achieve changes in the client's behaviour which is monitored over time.

1.5.2.1. Organising role of music

Inge Pedersen (1999) refers to music as a holding and organising tool for work with patients diagnosed with schizophrenia. Whilst holding and organising is a function of clinical improvisation in the Creative Music Therapy sense, these affordances are also facilitated through a behavioural approach to music interventions. Because of how music is structured i.e. through pulse, phrasing, metre, tempo and rhythm, it provides a means through which to offer patients a concrete, non–verbal, structured and focused experience. It is as if the music calls the patient into the 'here and now' and keeps the patient both focused and engaged through the intentional interventions of the therapist. Here the therapist would not so much employ free improvisation techniques, but structured musical exercises which require focus and concentration, listening and reciprocation and wherein the role of the therapist is more directive. Examples of this are structured instrumental improvisations, drumming exercises, vocal imitation, turn taking work and song writing.

1.5.3. Analytically Orientated Music Therapy (AOM) – The Priestly Model

Analytically Oriented Music Therapy (AOM) is a developed form of Analytic Music Therapy founded by Mary Priestly, a trained music therapist and violinist prominent in the 1970s. Priestly defines AOM as "the analytically-informed symbolic use of improvised music by the music therapist and client. It is used as a creative tool with which to explore the client's inner life so as to provide the way forward for growth and greater self-knowledge" (Priestly, 1994:3). In AOM clients are involved in active music making through clinical improvisation. The music therapist, the music and the client are jointly analysed in order to determine clinical goals and on-going clinical work. As stated earlier, Creative Music Therapy typically does not include verbal processing during or after improvisations with clients, whereas in AOM emphasis is placed on the salience of verbal processing after improvisations between client and therapist, which provide meaning and insight for the client and the ongoing therapeutic process. The

client-therapist relationship and transference phenomena are also emphasised in AOM (Wigram, 2002).

An AOM session is structured according to the following format:

1) ***Discussion***– client and therapist discuss what is relevant for the client in the present moment. This serves as the basis for identifying a working topic formulated into a playing rule for the joint improvisation between client and therapist.

2) ***Clinical Improvisation*** – the working topic is non-verbally explored through music and the therapist supports the client's music and may introduce a variety of musically interventions as and when clinically appropriate. The music can be tonal or atonal and it can include sections where either client or therapist play alone. The improvisation is typically recorded and played back to the client. This enables the client to reflect not only on the music making experience itself, but to receptively reflect through listening back to the improvisation.

3) ***Verbal processing*** – the role of verbal reflection is to bring to consciousness inner dynamics of the client that may have been present or evoked during the improvisation. Additionally, the improvisation is recorded and the client is invited to listen to the improvisation and reflect on what this may evoke. This provides the insight necessary for the growth and transformation of the client.

4) ***Final improvisation*** – an AOM session is typically concluded with a clinical improvisation based on insights gained during the verbal reflection between client and therapist (Wigram, 2002: 121-125).

1.5.4. Functions of the music

Active forms of music therapy express the role of music in different ways. Creative Music Therapy highlights the communicative, creative and expressive role of music. AOM highlights the role of clinical improvisation as a way of sounding unconscious processes. BMT refers to music's structuring and functional role, and resource oriented music therapy emphasises music as a means to accessing strengths and potential.

Dakovanou et al. (2012) refer to how music reflects psychiatric semiology and symptomatology. An example from a case study illustrates how logorrhea is reflected in the client's musical structure through perseverative playing, impulsivity became intensive playing, anxiety reflected through fast playing and repeated clusters sounded her fixation of ideas.

Smeijsters (2012) refers to the theory of analogy and metaphor as a means to understand the manner in which music works in clinical improvisation. Bunt & Stige (2014) refer to music as a resource for action and highlight the role of the elements of music such as timbre, pitch, loudness, silence, rhythm, melody and harmony as offering an array of sonic possibilities in the music therapy space which holds the potential for experiences of supporting, challenging and extending the client's music and therapeutic process. Clients respond to each of these elements in different ways thus affording therapeutic development unique to each client's process.

Finally, active music making in music therapy happens within the context of the client-therapist relationship. The client is not merely observed whilst making music, but is rather regarded as the musical partner of the therapist. Pavlicevic (1991) developed the Musical Interaction Rating Scale (MIRS), an assessment and therapeutic tool that assesses and describes one-on-one clinical improvisation work with adult psychiatric clients. The 9-level scale evaluates the quality of interaction between therapist and client, by considering client performance, client and therapist response, musical interaction, shared musical content and clinical adjustment: Level 1: No musical contact, Level 2: One-sided contact – No responsiveness from client, Level 3:One-sided contact – Non-musical responsiveness of client, Level 4: Self-directed musical responsiveness of client, Level 5: Tenuous musically directed responsive contact, Level 6: More sustained musically directed responsive contact, Level 7: Establishing mutual contact, Level 8: Extending mutual contact, Level 9: Musical partnership.

The musical qualities and the interaction between client and therapist are indicators of development and can help to identify the intricacies present in the therapeutic process, which informs ongoing planning and clinical decision making.

1.6. Receptive Music Therapy

Distinct from Active Music Therapy, Receptive Music Therapy refers to techniques that employ music-listening instead of music-making as the central focus of the intervention.

> "In receptive experiences, the client listens to music and responds to the experience silently, verbally or in another modality. The music used may be live or recorded improvisations, performances or compositions by the client or therapist, or commercial recordings of music literature in various styles (e.g. classical, rock, jazz, country, spiritual, new age). The listening

> experience may be focused on physical, emotional, intellectual, aesthetic or spiritual aspects of the music and the client's responses are designed according to the therapeutic purpose of the experience" (Bruscia, 1998a: 120-121).

This could include relaxation, music listening for pain and stress management, music listening techniques to elicit memories and associations, using the preferred music of a client as a means to create a safe therapeutic alliance and music listening as an aid to other forms of therapy e.g. Occupational or Physiotherapy.

Grocke and Wigram (2007) outline the following Receptive Music Therapy techniques as commonly used in clinical music therapy practice in various settings: i) music relaxation for children and adults, ii) imaginal listening, included unguided and guided imaginal listening, iii) song (lyric discussion), iv) song reminiscence, v), music listening based on client's preferred music, vi) music appreciation activities, vii) music collage, viii) somatic listening and eurhythmic listening (Grocke and Wigram, 2007: 16-17).

Whilst music listening is used in a variety of ways by music therapists from across the professional spectrum, Guided Imagery and Music - The Bonny Method (BMGIM) is regarded as one of the five internationally recognised models of music therapy and forms the basis of the discussion on Receptive Music Therapy.

1.6.1. Guided Imagery and Music – The Bonny Method (BMGIM)

BMGIM was developed by Helen Bonny, a trained music therapist and violinist, in the 1960s during her participation in a research study at the Maryland Psychiatric Research Centre. Helen Bonny's role in this research study was to select music during the experimental psychotherapeutic treatment of substance abuse and cancer patients with hallucinatory drugs such as LSD. Her interest was piqued and she began to experiment solely with the use of music with patients in an altered state of consciousness and discovered that music without the aid of drugs was powerfully evocative (Bonny, 2002). As a result of rigorous clinical research, Helen Bonny developed over 40 classical music programmes for specific clinical intentions. These programmes are 25-50 minutes in duration and comprise between 3 and 5 pieces of classical music. Bonny (1990) describes GIM as "a process where imagery is evoked during music listening". Wigram cites Goldberg's (1995) comprehensive definition of GIM as" a depth approach

to music psychotherapy in which specifically programmed classical music is used to generate a dynamic unfolding of inner experiences….(it is) holistic, humanistic and transpersonal allowing for the emergence of all aspects of the human experience: psychological, emotional, physical, social, spiritual, and the collective unconscious" (Wigram, 2002:115). Short et al. (2011) refer to the affordances of GIM as a method that "combines reflective and spontaneous imagery with carefully selected music to promote psychodynamic change, enhancing spontaneous inner exploration and development of the person" (Short et al, 2011:6). The premise of BMGIM is that music acts a projective tool, and that through images, associations and memories which are evoked through the music, material from clients' unconscious world can be brought to consciousness and processed during clinical sessions (Bonny, 2002).

A BMGIM session, 90 minutes in duration, comprises the following structure:

1) ***Pre-talk*** - the client brings presenting issues, which the therapist guides towards setting an intention, or focus for the music listening component of the session. Based on the theme of the agreed upon intention, the therapist selects an appropriate music programme.

2) ***Induction or relaxation*** – the therapist invites the client to lie in a comfortable position and guides the client through a relaxation process towards a deepened state of consciousness. At the conclusion of the induction, the therapist informs the client that the music will begin to play, reminding the client of their selected intention.

3) ***Music listening and dialogue*** – whilst the music is playing, through the use of guiding questions the therapist works with the imagery which is evoked by the music. The therapist assumes a non-directive approach, guiding the client through a series of non-leading questions. The music can evoke powerful imagery, emotional and kinesthetic experiences. GIM therapists are trained to skillfully work with a wide range of client responses to music listening. The music is regarded as the co-therapist and BMGIM programmes are structured in such a way that, at the conclusion of the music listening, the music, is able to contain (not necessarily resolve) difficult experiences that the therapist would reinforce as the session concludes.

4) ***Creative visual process and post talk*** – At the conclusion of the music listening component of the session, the client is invited to symbolise their experience through a visual representation in the form of a drawing. The therapist witnesses this maintaining a stance of availability to the client. The visual representation is very often the point of departure for reflecting, processing and integrating the client's experience of the music listening and dialogue component.

BMGIM is a specialised technique that illustrates in a sophisticated manner the evocative power of music listening and the role that symbolic work through imagery and metaphor can play in the treatment of a variety of client groups (Bonny, 2002; Lotter, 2011).

Whilst the 90 minute GIM session structure is usually contra-indicated for patients with schizophrenia-spectrum psychotic disorders, and is to be administered with caution for patients with a) weak ego-strength, b) those in the terminal phases of illnesses, c) clients who have undergone trauma and d) patients not stabilised on medication, it remains a useful model for conceptualising adapted clinical techniques appropriate to clients of this diagnostic group with varying needs. There are many creative ways in which music listening can be employed in clinical work where music is employed as a projective tool (Bonny, 2002). This study, thus, does not employ the BMGIM method in its totality, but the theoretical and clinical premises of the method informs the use of Receptive Music Therapy component of the music therapy intervention. The essential differences are that i) the full 90 minute session structure is not employed within this study, ii) shorter pieces of music, rather than complete music programs such as are used within BMGIM sessions, are used within specifically designed shorter Receptive Music Therapy techniques and iii) dialogue between client and therapist during music listening is not used during this study due to the abbreviated nature of the receptive techniques. The primary elements comprising a BMGIM session structure are adapted within the range of receptive techniques employed for this research. These elements include verbal discussion before and after the Receptive Music Therapy process, music listening and the use of drawing or clay work.

1.6.2. Adapted Receptive Music Therapy techniques

An adapted version of BMGIM is referred to as GMI (Guided Music Imagery). These interventions are usually shorter, following a similar session structure to BMGIM, but using a single piece of music or short music selection instead of a complete music program (Grocke and Wigram, 2007: 148, Bonny & Savary, 1990). Other forms of imagery and music work includes UMI (Unguided Music Imaging), DMI (Directed Music Imaging) and GrpMI (Group Music and Imagery) and MDN (Music, drawing and narrative) which combines three modalities as a vehicle for story making (Grocke and Wigram, 2007; Booth, 2005).

Central to Receptive Music Therapy techniques is the potential of music to stimulate a variety of experiences including visual experiences, memories, emotions and feelings, body sensations, body

movements, somatic sensations, altered auditory perception, pure music transference, associations and transference to the music, abstract imagery, spiritual imagery and spiritual experiences, transpersonal experiences, archetypal figures, dialogue, aspects of the shadow part of self and symbolic shapes (Grocke and Wigram, 2007: 134-135; Bonny and Savary, 1990). The symbolic material and responses to music listening hold the potential for catharsis and the client connecting with parts of self or parts of their lived story.

1.7. Communicative means supportive to music therapy

As may be deduced from above, the various kinds of music therapy may be seen as ways of communicating and relating. The music-making Active Music Therapy as well as the listening and responding in Receptive Music Therapy are ways of communicating and relating. Communication and relation in music therapy, however, extend beyond music-making and listening. Notably, verbal communication (words and sentences) and other symbols are intertwined with the activities of music therapy. These should thus be recognised as such in understanding the music-making of Active Music Therapy and listening of Receptive Music Therapy approaches**.**

1.7.1. Words and verbal interaction in music and music therapy

Within this blended music therapy approach the music making, music listening, verbal responses, creative visual processes and symbolic material co-exist interdependently and form the substance of each session. In particular, the relationship between the music and the words suggest that they operate as an extension of one another. Andersen (2012) refers to verbal interaction as relationally responsive practice where the focus is on dialogic conversation with clients. Knowledge and language are viewed as relational, generative and social processes. Nolan (2005) suggests that verbal processing affords increased client awareness through enhanced i) awareness about the music, ii) awareness about musical behaviour, iii) awareness about interpersonal processes, iv) awareness about emotional or cognitive experiences, v) verbal and non-verbal integration and vi) transition to a more defended state (Nolan, 2005: 21-24).

In some instances, one might consider the words as part of the music and the music flowing from verbal reflection. He refers to the musical and verbal process cycle, which affords a flow between verbal and

musical experiences and reflections (Nolan, 2005:26). The musical and verbal process cycle offers increased access to a broader range of communicative and expressive possibilities within the therapy space.

Metzner (1999), refers to the complementary and structuring role of the verbal and the musical used in combination, particularly in psychiatric settings stating that

> "in contrast to the purely verbal-oriented therapies, I believe that this approach is particularly appropriate for the treatment of patients who have problems with the regulation of closeness and distance, whose introspection and symbolisation ability is disturbed, and who otherwise are hardly capable of therapeutic splitting of the ego and partial regression. The alternation between improvisation and talking evokes ego functions and so has a structure-developing effect… This leads to my opinion of the usefulness of psychoanalytic music therapy in psychiatry, which is contrary to the prevailing view that music therapy is too egodisintegrating – especially in the case of psychotic patients – and so is contraindicated. Surely, this may be true in individual cases but cannot be generalised" (Metzner, 1999: 105).

Improvised song writing is a space where music and words happen together. Baker et al. (2008) identify the therapeutic benefit of including song writing in clinical practice as "a) experiencing mastery, develop self-confidence, enhance self-esteem; b) choice and decision making; c) develop a sense of self; d) externalising thoughts, fantasies, and emotions; e) telling the client's story; and f) gaining insight or clarifying thoughts and feelings" (Baker et al, 2008: 120). Songwriting is also valuable as music conveys messages and emotions, has clinical purpose and enhances self-expression (Baker, 2015: 122).

The words and the music are the focus of investigation in this research. Describing and analysing clients' musical expression as well as analysing verbatim verbal expression, with reference to verbal reflection, symbols, images, story text and song-writing, provides an overall sense of the affordances of the music intervention.

Of interest too, is how the participants reflect on their lived experience of the music therapy process. Limited research has been conducted internationally with regard to clients' experiences of music therapy. (Hammel-Gormley, 1995; Rolvsjord, 2010; Solli, 2014; Solli & Rolvsjord, 2014; Stige, 2012b). Research of this nature has not been conducted in South Africa and thus it was deemed important to

not just describe the experience within music therapy, but allow the participants to reflect on their experience at the conclusion of a course of music therapy.

1.7.2. Symbolic material

Wiener (1998), in her paper entitled "Living within darkness: psychiatric survivors and the protection of mythical language" illustrates, through two case examples, the role of myth and metaphor through creative therapeutic processes with psychiatric patients. Noteworthy in this approach is that it would seem that the language of myth and metaphor and the techniques she proposes facilitate 'meaning' for the patient through the therapist entering the symbolic world of the patient, drawing the patient into a creative working therapeutic alliance thus drawing them out of isolation into a space in which shared meaning is possible. "Clinicians can foster accepting and non-judgmental intentions in their work by responding to clients' metaphors, rather than simply focusing upon their suffering, perceived impairments, status of disenfranchisement or the embodiment of the psychiatric diagnoses assigned to them" (Wiener, 1998; 181). Short et al, (2011) emphasise the fact that "participants are using whatever is at their disposal to convey meaning and make sense of their experience even if it may seem ordinary or mundane. It is imperative that we listen, and try and understand the meaning on their own terms" (Short et al, 2011: 18)

In similar vein, in *Drama, Psychotherapy and Psychosis: Dramatherapy and psychodrama with people who hear voices,* Casson (2004) considered the role of drama therapy for patients suffering from psychosis and, in particular, looked at the potential of drama therapy to promote change without the necessity of insight and states that " it becomes possible, if not to integrate the split-off parts, at least to establish a relationship with them at sufficient distance, such that the person feels less threatened and more in control, with choices rather than ultimatums" (Casson,2004:241-242). The externalization through symbolic work through a projective screen which the creative arts therapies modalities offer, seem to provide clients with different means and vocabulary sources through which to journey through unbearable feelings in living with often unmanageable illnesses. These techniques include active music making, music listening, song writing, relaxation, imagery, symbols, creative visual processes, movement and clay work.

Van Lith (2015) incorporates the use of art and images as a tool for mental health recovery and identifies four affordances in this regard. i) Connection to inner self through immersion in the creative process, ii) developing a sense of achievement by creating art as a result of perseverance and increased concentration and attention span in the midst of the presence of symptoms, iii) motivational force when unwell and iv) creating a psychologically safe space and a reprieve from symptoms fostering experiences of comfort and belonging (Van Lith, 2015: 9).

The inclusion of the creative arts in music therapy opens up possibilities for communication, self - expression and accessing thoughts, feelings and inner resources. Hendersen & Gladding (1998) outline the following contributions of the creative arts in counselling: i) draw people out of self-consciousness and into self-awareness by having them express themselves in a symbolic manner, ii) call attention to the process of expression, iii) provide a set of concrete experiences clients can carry with them to help them relate to others and themselves, iv) develop new ideas and interests to use in relating to themselves and others outside of counselling, v) promote positive feelings and affect within people that can be tapped when celebrating and coping with life's highs and lows and vi) engender hope, confidence, and insight.

1.8. Conclusion

This chapter situates this research study in established approaches of music therapy and its underpinning theories as how they apply in the context of mental health, specifically, for patients with major depressive disorder and schizophrenia-spectrum psychotic disorders. I emphasise most suitable for a South African context of *ubuntu* and *batho pele*, the relational aspects of music therapy and how these find expression in the various music therapy techniques

For the purpose of this research, the music therapy conducted comprised a blended approach of different forms of active and receptive techniques. All participants were exposed to all the techniques planned for this intervention. As will become evident in the analysis and findings is the manner in which each client's process was unique as well as how individual clients engaged with different aspects of the intervention. The blended approach employed in this research offered a range of opportunity for clients to engage in the process through music listening and music making, through using words and through participating in music-centred techniques that included drawing, clay work, movement and relaxation.

This range is broader than a more technique selective approach, allowing engagement in the “terms” with which the client relates spontaneously. This technique-open approach, so to speak, resonates well with qualitative methodology in that the spontaneity and subjective preference of the client are given a key and leading place in conjoint understanding and the co-creation of meaning verbally and in music making.

The next chapter provides a detailed account of the research methodology, describing a qualitative design that is suitable for addressing the main objectives of this study: that is, to explore the musical and verbal affordances of Active and Receptive Music Therapy techniques in the treatment for major depressive disorder and schizophrenia-spectrum psychotic disorders. The subsequent chapters report on the findings and conclude with an appraisal of the study, reflecting on the affordances and their implications for clinical practice and future research.

Chapter 2: Research Methodology

This chapter presents the aims and objectives of this study, the research paradigm, design, population, sampling, a description of the data collection and analysis processes.

2.1. Aims and Objectives

This study aimed to explore, describe and compare qualitative affordances of a music therapy intervention comprising Active Music Therapy (AMT) and Receptive Music Therapy (RMT) techniques, respectively and in combination, among patients suffering from major depressive disorder and schizophrenia-spectrum psychotic disorders

The objectives of the study were to:

a) describe the qualitative affordances and contribution of AMT and RMT techniques respectively and combined in the treatment of patients suffering from major depressive disorder and schizophrenia-spectrum psychotic disorders respectively;
b) compare the music therapy techniques respectively and in combination for their qualitative affordances;
c) Compare the qualitative affordances of the music therapy techniques between the two diagnostic groups i.e. major depressive disorder and the schizophrenia-spectrum psychotic disorders. The comparison aimed to explore the best fit between the diagnostic groups and the music therapy techniques.

In sum, of specific interest to the research study is a) individual response to music therapy techniques; b) similarities and differences of the affordances when the music therapy techniques are compared; similarities and differences of affordances when the patient groups are compared c) best fit of technique to diagnostic group. Table 2.1 summarises the methodological steps, data sources and classification of different theme sets in addressing the objectives for the study.

Table 2.1. Summary of methodological steps, data sources and theme classification

Describing and comparing RMT's and AMT's respective and combined affordances	
(1) Theme set I	13 themes: from verbal responses (to/during RMT and AMT) as illustrated by visual images, text, audio example and direct verbatim quotes *(Chapter 3, Table 3.1)*
(2) Theme set II	12 themes: from post-therapy in-depth interviews (*Chapter 3, Table 3.28)*
(3) Theme Set III	10 themes; from observed participation in AMT by therapist – with reference to the musical qualities of rhythm, dynamics, tempo, phrasing and pitch (*Chapter 4, Table 4.1)*
(4) Appraisal of Themes	11 "voices": comparing Theme Sets I-III (Chapter 5) • RMT and AMT's respective and joint contributions • Affordances respectively in depressive and schizophrenia-spectrum participants, and both (*Chapter 5, par 5.2)*

This study did not set out to explore progress over time as this fell beyond the scope of this study. It is anticipated, however, that this research would contribute to a greater understanding of music therapy interventions for patients for the above-mentioned diagnostic groups.

2.2. Nature of the qualitative affordances

The following kinds of qualitative affordances were pursued in the exploration:

2.2.1. Musical qualities being the tone pitch, timbre, dynamics (tone volume and its changing), phrasing, melody, harmony, meter, rhythm, instrumentation and other usual musical descriptors. This applied to all aspects of music making within the session i.e. the client's music, the therapist's music and the joint music of client and therapist.

2.2.2. Verbal expression of the client was described and analysed. This included any verbal component within the music making context, verbal responses to Receptive Music Therapy techniques and active music making as well as any content that emerged in the conversations between the client and the therapist.

2.3. Ontology, Epistemology, Paradigm and Design

The ontological stance of this qualitative research study is constructivist positing that objective reality is neither a prerequisite assumption nor of concern but rather, multiple realities are constructed by human beings who experience a phenomenon of interest (Krauss, 2005: 760). Reality is experienced as consciousness and constructed through subjectively experiencing and making meaning of the world (Gray, 2004:17; Terre Blanche & Durrheim, 2006:6, Ormstom et al. 2013; Scotland, 2012:11).

Congruent with the ontological orientation of this study, an interpretivist epistemology underpins this research. It posits that the generation of knowledge occurs naturally with and between people through direct observation, description and interpretation, employing an inductive approach to gaining knowledge (Ormstom et al. 2013:6; Scotland, 2012: 12). The subjectivity of both the observed and the observer is acknowledged, and a value-mediated, reflexive approach to observation is advocated in order to manage and keep values, biases and assumptions transparent within a non-judgmental approach (Ormstom et al, 2013: 8).

Vasilachis de Gialdino (2009), states that an interpretive paradigm upholds four basic principles: "i) resistance to the "naturalization" of the social world; ii) relevance of the life-world concept; iii) transition

from observation to understanding and from the external to the internal point of view; and iv) a recognition of double hermeneutics. These assumptions are specifically linked to a view of language "as a resource and a creation, as a way of producing and reproducing the social world' " (Vasilachis de Gialdino, 2009:1).

Denzin and Lincoln (2005) define qualitative research as "a set of interpretive, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings and memos to self. Qualitative researchers study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them" (Denzin and Lincoln, 2005:3)
Forinash and Lee (1998) state that "Qualitative research has an emergent focus or design, in which the research methodology evolves, rather than having a pre-set structure or method, thus allowing the process to determine the direction of the investigation. This particular concept is appealing to many music therapists because of the parallel emergent focus in the creative process. In qualitative research the aim is not to produce predictive generalizations, but rather a more concentrated and in-depth application of the finding" (Forinash and Lee, 1998:143). The findings are thus context and situation specific and may only be generalised hypothetically to contexts and situations that are similar.

This study is a naturalistic inquiry which recognises that inquiry itself cannot be detached but is value-bounded by the perspectives of the researcher. Within these cases, plausible inferences on events and processes are made, but cannot lay claim to causality (Gray 2004:23).

Phenomena can only be understood within their environment or natural setting; they cannot be isolated or held constant while others are manipulated as in the case of experimental research. Naturalistic settings are complex and diverse wherein multi-layered meanings exists and possible to uncover. Research designs cannot be pre-specified, but 'emerge, unroll, cascade, or unfold during the research process' (Gray 2004: 23, Lincoln & Guba, 1985: 142). As is congruent with the methods of naturalistic inquiry this study employed aspects of participant observation, in-depth interviewing, transcription and thematic analysis as means to address the objectives of this research.

Central to this research are the participants themselves – their voices, their musical and verbal responses and their experiences of the music therapy process. Whilst this study does not employ

Interpretative Phenomenological Analysis, the principles of phenomenological research, which places emphasis on lived experience, are drawn upon for this research.

Finlay (2011) refers to descriptive phenomenology as being grounded in the philosophies of Husserl who postulated phenomenology as the study of the essence of conscious experience and Merleau-Ponty who held that things in the world are known because the experience is connected to and simultaneously evoked in the lived body (Finlay, 2011:43,54). Emphasis is placed on honouring what is given, working with the 'whatness' of the phenomenon before too quickly assigning meaning. The researcher's stance is to bracket previously held assumptions, values, and previously held understanding in order to work with what is present, which, in the case of this research is the musical and verbal voice and experience of participants. Rigorous description and staying true to the phenomena as they appear in the raw data are principles upheld by this study. Every effort was made not to impose a frame on the data but rather to allow the voice and experience of clients to emerge and be expressed through the resulting themes.

This study is partially informed and resourced by arts based research. Arts based research seeks to honour both the participants' experiences as well as integrate the primary medium of clinical practice, which, in this case is the music (Beer, 2016:33). It is postulated that when the creative arts are included in the data findings, the reader becomes part of an interactive event that affords contextualization and intellectual comprehension through what is read in the written text, as well as emotional and intuitive response through what is heard in the musical examples and observed in the visual images (Beer, 2016:33). A review of literature suggests few studies that incorporate musical excerpts as part of data findings. This research study presents musical excerpts, visual images and photographs of clay image making as part of the findings. Barone and Eisner (2012) state that "arts-based research values the ability of the creative arts to transform perceptions and expand consciousness through dialogue and the aesthetic engagement of social phenomena' (in Viega, 2013: 38). This knocks on the door of considering what it means to reflect on both artistic and scientific knowing, in researching human experience through the arts (McNiff, 1998b: 2011).

Implicit in this paradigm is the notion that meaning is multi-layered and seeks not to prove one single truth but rather to uncover meaning at numerous levels. The design for this study is the case study design where the specific participants and their context constitute the case. This is an idiographic approach not to establish the general case but to characterise the context-specific case (Aldridge, 1996;

Aldridge, 2005). Case studies in relation to each other can build up a body of evidence on which to build theory and contribute to the broader field of practice. The focus is, accordingly, the emergent nature of each client's music therapy intervention in relation to the qualitative affordances i.e. musical qualities and verbal processing.

2.4. Population and sampling

Flick (2007) distinguishes between sampling methods in quantitative and qualitative research and suggests that sampling in qualitative research is purposive where participants are selected from an existing or assumed population. Sampling is seen as setting up deliberately selected participants, materials or events for studying the phenomenon of interest in the most instructive way (Flick, 2007:27). For the purposes of this study selection was assisted by the opinion of psychiatrists and clinical teams in applying the inclusion and exclusion criteria described below. Based on clinical assessment, the clinical team referred patients, who met the inclusion and exclusion criteria, for the music therapy intervention. Thus, the purposive sampling was principally in terms of perceived suitability for music therapy within diagnostic parameters deriving naturalistically in a particular setting, even though the diagnostic parameters being informed by the standard diagnostic classification (DSM-5) used routinely in this setting.

2.4.1. The inclusion criteria were:

- Patients meeting diagnostic criteria for a major depressive disorder who currently experienced a major depressive episode as specified by DSM-5;
- Patients with a diagnosis as specified by DSM-5 criteria for any of the disorders in the DSM-5 category of schizophrenia-spectrum and others psychotic disorders in an acute phase;
- Patients who were currently hospitalised in Weskoppies Psychiatric Hospital;
- Patients with or without previous experience or training in music;
- Patients who gave informed consent to participating in this research.

2.4.2. The exclusion criteria were:

- Patients who experienced psychotic symptoms concurrently to a major depressive disorder;
- Patients who experienced a major depressive episode concurrently to a schizophrenia-spectrum psychotic disorder;

- Patients who were not capable of giving informed consent to participation in this research. The clinical team responsible for the patient was consulted as to ensure that participants were assessed as being capable in this regard;
- Patients who had been intoxicated in the preceding week before enrolment in the study;
- Patients who had a diagnosis of substance dependence;
- Patients who suffered from a comorbid psychiatric disorder in addition to the disorders of inclusion criteria 1 and 2 above that might influence the findings of the study;
- Patients who suffered from a comorbid neurological disorder that might influence the findings of the study;
- Patients who would not have been able to comply with the study requirements.

Ten participants were sampled from each of the two patient groups: major depressive disorder and schizophrenia-spectrum psychotic disorders. Eight male and twelve female patients participated in the study and the age range was between 18 and 57 years. A total of 131 sessions were conducted during the period February 2014 and December 2015. Since the study was not tracking progress over time, it was agreed through supervision, that data of all participants would be included as data even if clients did not complete all eight sessions (see Table 2.1 and 2.2. for the actual number of sessions that materialised for each client). An additional 2 participants had participated in two and one sessions respectively, but the data were not included in the analysis, as it transpired as more information emerged that they did not meet the inclusion criteria. The client who attended two sessions was admitted to a substance abuse rehabilitation program after the second session, and another client who attended one session was discharged from hospital and he could not continue participating in the study.

The site for this research was Weskoppies Psychiatric Hospital, a large public mental health facility in South Africa providing quaternary level psychiatric health-care. Music therapy sessions took place in a designated space that remained consistent throughout the data collection process. Patients either made their own way to sessions or were accompanied by nursing staff or myself.

Image 2.1. Photograph - music therapy room

The room was equipped with an electric keyboard, djembe and conga drums, a classical guitar, xylophones, wind chimes, a rain stick and a range of smaller percussion instruments. A camera was set up in the corner of the room as all sessions were video-recorded. A laptop with speakers was used to play all the pre-recorded music. Art materials in the form of sketch paper, pastels, clay, writing paper and a pen were available.

2.5. Interventional procedures

In addition to the standard psychiatric care as determined by the clinical teams that all participants receive, each consenting participant was scheduled to attend a total of eight, one hour twice weekly music therapy sessions. The actual number of sessions that materialised for each participant is presented in Tables 2.1 and 2.2 below.

Table 2.2. Session and interview participation – MDD-group

Session and Interview Attendance Summary: Major Depressive Disorder Diagnostic Group (n=10)			
Client A	Female	8 sessions	Post-therapy Interview
Client B	Male	1 session	Subsequent course of ECT, after which chose not to resume music therapy
Client C	Female	1 session	Withdrew after first music therapy session
Client D	Female	5 sessions	Discharged from hospital leading to premature termination
Client E	Female	8 sessions	Post-therapy Interview
Client F	Male	8 sessions	Post-therapy Interview
Client G	Male	8 sessions	Post-therapy Interview
Client H	Female	8 sessions	Post-therapy Interview
Client I	Female	8 sessions	Post-therapy Interview
Client J	Female	8 sessions	Post-therapy Interview

Table 2.3. Session and interview participation – SS-group

Session and Interview attendance summary: Schizophrenia- Spectrum Disorder Diagnostic Group (n=20)			
Client K	Male	1 session	Withdrew after first session
Client L	Female	4 sessions	Discharged from hospital leading to premature termination
Client M	Male	8 sessions	Post-therapy Interview
Client N	Male	8 sessions	Post-therapy Interview
Client O	Female	8 sessions	Post-therapy Interview
Client P	Female	8 sessions	Post-therapy Interview

Client Q	Male	8 sessions	Post-therapy Interview
Client R	Female	7 sessions	Posy-therapy Interview
Client S	Female	8 sessions	Post-therapy Interview
Client T	Male	8 sessions	Post-therapy Interview

The music therapy sessions were structured in such a way as to frame music therapy sessions uniformly across participants, but be flexible enough to accommodate the nuances of each patient's unique process. The intervention included a range of Active and Receptive Music Therapy techniques being a) guided relaxation and music listening, b) structured drumming exercises, c) unstructured improvisations that were developed and extended during each session, d) movement exercises, e) vocal work, focusing on both structured songs as well as free improvisation, f) a range of music listening techniques comprising a range of arts therapies modalities and g) song writing.

The first session was planned as a therapeutic assessment session during which Active and Receptive Music Therapy techniques were conducted. Patient response in terms of the qualitative affordances, musical qualities and verbal expression were observed and described. This served the purpose as a baseline from which to begin with each patient and a reference point for the qualitative analyses.

The following provides an outline of the music therapy session planning for the 8-week intervention:

Table 2.4. Session outline – 8-session music therapy intervention

Outline for music therapy intervention: Sessions 1-8 Session plans, interventions, techniques and selection of music pieces remained consistent for all sessions, but remaining within the structure, the individual process of each patient required flexibility and appropriate response. The few occasions where technology problems were encountered and live music was performed instead of pre-recorded music were recorded and transcribed accordingly. **Session 01** A music therapy assessment employing Active and Receptive Music Therapy techniques will be conducted. This will serve as a baseline from which to begin with each patient and as a qualitative reference point. 1. Relaxation and music listening (each session will start with relaxation with a different piece of music) RMT A love idea ...Mark Knopfler

2. Drumming (patient and therapist each play djembe drum) AMT
   a. Joint improvisation
   b. Turn taking exercise
3. Provide a range of small percussion instruments – client invited to select three instruments during the course of a structured song in ABA form: Folk song: Let it be (Beatles)/improvisation
4. Movement with music. Seated or standing as per client's choice- La Bamba
5. Vocal improvisation using 2 chord guitar chord sequence AMT A maj 7 D maj7
6. Music listening and drawing – the client will be invited to draw as the music plays. No specific intention will be given the client. The client will be invited to verbally reflect on the process. RMT Sunsinger - Dolphin Morning
7. Conclude session with brief drumming improvisation. AMT invite client to start

Session 02

1. Relaxation Vincent - Woven Moments
2. Drumming
   a. Joint improvisation
   b. Mirroring exercise
3. Improvisation with therapist on keyboard with client playing three instruments selected from previous week. Therapist to play a different piece of music for each section of the improvisation
4. Movement - Mirror Image (Seated movement) Leto/Wesnu: Medieval Voices
5. Song on guitar leading into vocal improvisation Non lyrical section of Hey Jude leading into improvised section
6. Music listening and drawing exercise: 'Sonic Sketch 1' (8 pieces of contrasting music edited to play as one piece with each piece fading out after a minute.) Invite to listen to the music and use colours or text to represent different aspects of self. Verbal processing to follow)
7. Conclude with brief drumming exercise which may link to verbal processing after Receptive Music Therapy technique

Session 03

1. Relaxation: Saint –Saens: The Swan
2. Drumming
   a. Joint improvisation

b. Drum and voice

3. Keyboard and 3-instrument improvisation developing from Session 02
4. Vocal improvisation with guitar (The song Hey Jude - Beatles- as the basis for the vocal improvisation)
5. Movement: Mirror Image (seated) Song from a secret garden: Secret Garden
6. Music listening and drawing: Music and emotions - Invite clients to use image or text to depict the emotions elicited by the music: Peter Hamner - Revelation
7. Conclude with drumming (which may be linked to verbal processing from receptive technique)

Session 04

1. Relaxation: Secret Garden: Serenade of Spring
2. Drumming
   a. Joint improvisation
   b. Conga and Djembe drum improvisation
3. Opening the music space – providing a larger selection of instruments extending the improvisation. Based on Sessions 2 and 3
4. Mirror Image Movement (contrasting piece of music) Body Tape (GIM) -Shostakowich piece
5. Music Listening and Clay work: Before/After Exercise. Use music on Keys CD (Anna's Theme Red violin and Schumann Funk)
   Conclude with an improvisation based on client's experience of this component.
6. Conclude session with client on Conga drums (or instrument of choice) and therapist on piano

Session 05

1. Relaxation - Misty (Woven Moments)
2. Drumming (Djembe and Conga)
   Joint improvisation
3. Opening the music space – providing a larger selection of instruments including melodic instruments i.e. xylophones and chime bars. Improvisation will include a vocal section. Therapist to play keyboard and guitar during improvisation.
4. Movement where client and therapist take turns in choreographing the movement
   Maifikizolo - Marabi

5. Music Listening and Story Writing exercise - (The Orphan, The Seeker, The Emperor, The Sage - from Myths and Archetypes: GIM)
6. Conclude with client on Conga drums (or instrument of choice) and therapist on piano

Session 06

1. Relaxation - Andante - Mozart
2. Drumming (Djembe and Conga)
   Joint improvisation
3. Opening the music space – free improvisation (to build on work and musical themes developed with each client from previous sessions)
4. Movement where client is invited to lead the activity. “You raise me up” - choreography based on lyrics (client led)
5. Music Listening exercise: Single Piece and Draw (a specific intention will be set for each client based on Client’s individual process to date) Peter Hamner "The Journey"
6. Conclude with client on Conga or djembe drums (or instrument of client’s choice) and therapist on piano (may be linked to other components of the session)

Session 07

1. Relaxation - Pachelbel Canon
2. Extend the improvisation and music space to include drumming, percussion instruments, melodic instruments and voice. Free improvisation.
3. Movement – Mirror Image Dance using a larger area – therapist to model ideas and client then invited to take the lead - La Diva “Summer”
4. Music Listening and Drawing: Three Circles Exercise (Three Circles Confrontation -Music)
   Intention based on what is relevant to client's process.
5. Improvisation – set an intention for an improvisation arising out of the processing of the 3 circles exercise
6. Conclude with a reflection on the improvisation.

Session 08

1. Relaxation - Rain Forest/ Sounds of Nature track 1
2. Invite each client to choose how they wish to end the music therapy process together by drawing from any of the work done in previous sessions. Client's choice
3. Music Listening Transformation Exercise (Place a range of words on the floor: Client to identify word/s with which he/she resonates, create symbol (clay or drawing), allow symbol to transform as music plays, verbal reflection) Music: Walking the path
4. Conclude with piano and conga drum improvisation based on verbal reflection.
   The music therapy process will be concluded at this point.

2.6. Post therapy in-depth interview

At the conclusion of the final session, an in-depth interview guided by a semi-structured interview schedule was conducted with each patient individually (see Table 2.4). Fifteen patients participated in interviews, seven of whom completed all eight sessions, and one patient; who could not attend the 8th session, was interviewed at the conclusion of that session. The semi-structured interview schedule was used to invite reflective content on all sessions, but with a very flexible application according to the patient's response and engagement with the interview questions. The open-ended nature of the questions in the schedule intended to ensure that as little as possible content would be suggestive or imposed on the subjectively important content.

Table 2.5. In-depth interview: Semi-structured interview schedule

Semi-structured interview schedule administered at the conclusion of the Music Therapy process
1. What words would you use to describe your experience of the Music Therapy sessions?
2. Describe your experience of the following aspects of our sessions: -Drumming -Improvising with different instruments -Relaxation to music -Music listening exercises

	-Movement
3.	How did the music therapy sessions make you feel?
4.	What did you experience as most helpful during the sessions?
5.	What did you experience as least helpful during the sessions?
6.	What did you learn about yourself during the music therapy process?
7.	Can you think of one experience during our process which stands out for you?
8.	If you were to continue with music therapy sessions what would you like to do more of?
9.	If you were to continue with music therapy sessions is there anything you would change?
10.	How has the music therapy affected you in daily living?

2.6.1. Post therapy interview processing and ("field") notes

The interviews were audio-video recorded and transcribed verbatim. There were occasions, prior to switching the camera on that I had done a basic and general description of the interview so the client knew what to expect. The interviews were conducted in conversation style, where the above-stated questions guided the interview and formed the basis of other interview questions pertinent to each interviewee's responses. The interviews were primarily conducted in English, although where appropriate Afrikaans was also used. In the case of some interviews, questions were phrased differently but as close to the interview schedule as possible as some clients had difficulty understanding questions and articulating responses due to a) language difficulties in some cases and b) the possible impact of pathology and medication. In the case of the interview with Client G, the video recording stopped short of the interview as indicated on the transcription. I added an extra paragraph from what I could recall from the interview section that was not recorded – this was not used in the interview analysis, as only verbatim responses of clients were analysed. In the interview transcripts I indicated, for the external

researcher, where a) words or phrases were inaudible or b) placed a question mark next to a word I was unsure of. The term “mm” used often by the therapist in the interview, indicates an acknowledgement of client’s statement and not necessarily an agreement. Included in brackets is information about gestures in the interview or references the clients make about specific techniques or experiences in the music therapy sessions. In the case of interview 3, in which the client enquired about what would happen to the video footage, a detailed response was given to the client during the interview.

All patients affirmed the process of informed consent to this research by signing an informed consent document. A full explanation of this document, including information concerning video recording of sessions was provided for the client at the commencement of the music therapy process. Finally, in some instances clients were interviewed on the day of their final session as they were due for discharge from hospital and another additional time may not have been suitable.

2.7. Data preparation and analysis

To ensure that analysis is credible and transparent to others, analytical approaches should be systematic and comprehensive. The analysis should follow a set of procedures and the same procedures should be applied to all the cases and all the data since as Matthews and Ross (2010) state, qualitative data can take many forms and is relatively unstructured. Second, as the data exist in their raw state initially, that one must be able to return to the raw throughout the analysis. Third, it is emphasised that, as is the nature of qualitative research, the full analysis cannot be planned at the beginning of the process as ideas and themes ‘emerge’ as part of the working process, so the approach itself must be dynamic and flexible and allow for changes. Finally they iterate the need for analysis to be accessible. The researcher’s interpretations and the way these are used to develop the analysis must be open and understandable by others (Mathews and Ross 2010:373)

Miles and Huberman’s (1994) qualitative data analysis interactive model, known as transcendental realism, has three main components, i.e. data reduction, data display and drawing and verifying conclusions. In the early stages the data are edited, segmented and summarised. In the middle stage codes are organised into emerging categories from which, during the later stage, overarching themes are identified and discussed. (Miles and Huberman, 1994: 174).

The rigour of research demands that codes, categories and themes emerge from the data rather than being imposed on the data. It is essential to ensure that coding is as analytic and systematic as possible.

Line by line coding is a technique suggested by grounded theorists. This enables comparison of similarly coded texts with each other, different codes with each other, and coding between cases (Gibbs, 2007: 54).

This study extended the coding and analyzing of verbal content, as is customary in content and thematic analysis, to describing musical content, which at its core is non-verbal. The verbal description of the non-verbal phenomenon was subject to the same analytic procedure described below.

2.7.1. Data sources

Data source A: Detailed descriptions of patient response in respect of musical qualities, and verbal processing (verbatim) were transcribed from audio-video footage of each of the 131 sessions. Data source A also includes a record of visual and clay images and story texts generated during the sessions. These are referred to in the findings chapters. (For an example of the transcription see: Appendix I)

Data source B: Semi-structured post therapy in-depth interviews were conducted with 15 participants at the conclusion of the 8-session process of music therapy as detailed above. The in-depth interviews were audio-video recorded and transcribed verbatim by the therapist-researcher. The interviews were analysed independently by a registrar in psychiatry, Dr. Natalie Paul, constituting a sub-study of this study as approved by the relevant postgraduate committees of the Faculty of Health Sciences. The findings of the study are summarised in this thesis and serve as potentially corroboratory evidence to the findings on the data generated during the music therapy sessions.

Data source C: Reflection notes were written at the conclusion of each session. These notes were important for capturing immediate reflections, thoughts and feelings after each session. These session notes were not analysed per se but were used supportively to clarify and verify content and context (see Appendix II for an example of clinical session notes).

2.7.2. Data analysis procedure: Data source A

Step 1 – Transcription of audio-video recorded music therapy sessions

An excel spreadsheet was designed for the purposes of transcribing and coding the 131 music therapy sessions (see Appendix III for example spreadsheet). A worksheet was allocated per Client and named accordingly Client A, Client B etc. Each column represented a technique or component of the music therapy session (e.g. Conversation at start of session, Relaxation, Drumming improvisation, Instrumental improvisation etc.) that covered the full 8 session music therapy intervention. Adjacent to each component was a numbered column (A1, A2, A3 etc. The numbered columns were for the purposes of segmenting data in the adjacent, corresponding cell (e.g. A1 segments pertaining to 'Conversation at start of session). B1, would therefore refer to the same session component, but apply to Client B.

Client - A (MDD)	Session No	Date	Conversation at start of session	Coding A1	Relaxation	Coding A2	Drumming Improv	Coding A3
	Session 1							
	Session 2							
	Session 3							
	Session 4							
	Session 5							
	Session 6							
	Session 7							
	Session 8							

Figure 2.1. Example Excel spreadsheet – data transcription of video recorded music therapy sessions

The therapist-researcher transcribed each session in full. The transcription was organised according to the above-described spreadsheet, as illustrated in figure 2.1. There were 26 columns in total.

Transcriptions within each cell are hereafter referred to as data chunks (see Figure 2.2.). Verbal interaction between client and therapist was transcribed verbatim. In a few instances where verbal content was too detailed, and not directly applicable to the focus of the study, a paraphrased description was written. The video footage was used to clarify the context and content of transcriptions.

Clients' participation in active music making processes was described in detail by the therapist-researcher. Deliberate continuous effort was made as not to infer interpretation on the client's music at this stage (i.e. of the data collection) other than attempting to describe the quality of a client's music (e.g. busy, loud, tentative) or movement (stiff, flexible, energetic) as unequivocally as possible.

Vocal dialogue	Coding A17	Song writing	Coding A18	Music Listening Open Intention	Coding A19
"Just like we did on the drums. You want to start?" "Please start" "Shall I start? ...you can sing anything you like" I continue playing in G major and sing a short melodic phrase. The client answers, her voice stronger than during the vocal improvisation, pitch lower. Her musical material is her own. Although she looks down while singing, when it is my turn she looks up at me often smiling. Again she laughs when it seems that she does not know what to sing, "anything, any sound. stay with doo-doo if you like" The client begins to sing again and this time sings a longer phrase. She sings more confidently and begins to extend the melodies and phrases. i respond with similar musical material. She negins to explore with a variety of vocal sounds. Continues to move body to the rhtythm as she sings. Vocal dialogue comes to an end when client stops singing, laughs and is quiet. I quieten the music and encourage the client to sing with me. This builds into a crescendo, increasing the tempo and energy level of the vocal improvisation before ending with a decrescendo and ritardando, bringing it to an end, where we both sustain the last night in a playful manner and when we finish she puts				"I introduce the music listening technique to the client. "Close your eyes, listen to the music for a while, see what it brings you and then at a certain point when you are ready you can just start to draw as the music plays, in terms of what it is bringing you" DOLPHIN SUNSINGER After listening for a while client asks "can I draw?" Yes, you're welcome to start" "I'm not good at drawing" "It doesn't matter, you can use colours or shapes, or words. Whatever you want to do" Client talks while drawing. Drawing: Bird, Apple Tree, waterfall, river with fish. Wrote text on drawing after verbal reflection: " It is a place I wanna be, no stress no pain, no suffering, not waking to a day when you feel it should never be. A sense where there is love laughter,	

Figure 2.2. Example of transcribed data chunks

Step 2 – Segmentation of transcribed session components

Each transcribed column (e.g. Vocal dialogue) was then segmented in the column adjacent to the description. The segments of data, hereafter referred to as level 1 codes, within each cell were labeled as follows: 1a), 1b), 1c) etc., as illustrated in figure 2.3.

Vocal dialogue	Coding A17	Song writing	Coding A18	Music Listening Open Intention	Coding A19
"Just like we did on the drums. You want to start?" "Please start" "Shall I start? ...you can sing anything you like" I continue playing in G major and sing a short melodic phrase. The client answers, her voice stronger than during the vocal improvisation, pitch lower. Her musical material is her own. Although she looks down while singing, when it is my turn she looks up at me often smiling. Again she laughs when it seems that she does not know what to sing, "anything, any sound. stay with doo-doo if you like" The client begins to sing again and this time sings a longer phrase. She sings more confidently and begins to extend the melodies and phrases. i respond with similar musical material. She negins to explore with a variety of vocal sounds. Continues to move body to the rhtythm as she sings. Vocal dialogue comes to an end when client stops singing, laughs and is quiet. I quieten the music and encourage the client to sing with me. This builds into a crescendo, increasing the tempo and energy level of the vocal improvisation before ending with a decrescendo and ritardando, bringing it to an end, where we both sustain the last night in a playful manner and when we finish she puts	1a) offers explanation, 1b) invites client to lead, 1c) Please start 1d) leads music, 1e) client responds, 1f) voice stronger, 1g) independent musical material, 1h) increasing eye contact, 1i) uncertainty , 1j) shy laughter, 1k) encourage client to continue, 1l) voice more confident, 1m) explorative vocal sounds, 1n) extending musical material, 1o) engaged body language, 1p) vocal dialogue evolves into joint improvisation, 1q) music jointly negotiated with contrasts, 1r) music playful, 1s) mutual enjoyment, 1t) affirms client, 1u) I was so nervous, 1v) encourages client, 1w) positive body language			"I introduce the music listening technique to the client. "Close your eyes, listen to the music for a while, see what it brings you and then at a certain point when you are ready you can just start to draw as the music plays, in terms of what it is bringing you" DOLPHIN SURSINGER After listening for a while client asks "can I draw?" Yes, you're welcome to start" "I'm not good at drawing" "It doesn't matter, you can use colours or shapes, or words. Whatever you want to do" Client talks while drawing. Drawing: Bird, Apple Tree, waterfall, river with fish. Wrote text on drawing after verbal reflection: " It is a place I wanna be, no stress no pain, no suffering, not waking to a day when you feel it should never be. A sense where there is love laughter,	1a) Offers instruction and explanation, 1b) client seeks clarity, 1c) expresses lack of ability to draw, 1d) encourages client, 1e) visual material nature scene, 1g) desired state of being, 1h) experienced music listening as peaceful, 1i) no interruptions 1j) desire to be in a place with no pain, no depression, 1k) experienced visualisation from distance, 1l) desire to be in the place she visualised, 1m) encourages client to use symbols as a tool, 1n) suggests client visualises imagery from session when back at ward, 1o) acknowledges difficult reality of client, 1p) offers practical suggestions to client, 1q) expresses reservation, 1r) agrees to try

Figure 2.3. Data segmentation

A level 1 code would, therefore, be referenced as such: A17 1a:

'A' indicates Client A,

'17' refers to Column 17, segmented phrases from Vocal dialogue data chunk,

'1' refers to session 1

'a' refers to the first segment in that cell.

The data were transcribed using a colour key to denote different aspects of the transcription. This was for ease of identifying aspects of the data, as well as making provision for further analysis of data.

Step 3 – Organising data segments into level 2 codes

The next step was to organise the level 1 codes into level 2 codes. In order to do this I extracted three sets of Level 1 codes from the transcribed spread sheets: i) Level 1 codes pertaining to the client's active music making (these were the emerging musical content), ii) Clients' verbal responses concerning active music making and iii) Clients' verbal responses to Receptive Music Therapy techniques. Each Level 2

code was assigned a number (e.g. Difficult VR94). This resulted in a total of 340 Active music making level 2 codes and a combined 359 verbal response level 2 codes. Figure 2.4 provides an example of the Level 2 coding.

Venturing Out (VR93)	Difficult (VR94)	Inner Resources (VR95)
A25 7u) referring to third circle- outside it's tough	A25 7g)the journey is very, very difficult	A25 7i) I have to use what I've got
E22 4m) I want to tell people my story ?	A25 7h) I get a lot of obstacles	F22 4n) solid, not empty
E24 6k) coming out of cocoon	B19 1l) I'm confused because this is very difficult	F22 4o) something inside
E25 7ab) It's ok to come out. It's not a scary world	B19 1w) I find life hard - in making sense of it	G24 6g) Listen to my gut.
E25 7ac) Getting out of my safe space	A23 5c) Story Title: The worst journey to be endured	I26 8i) creating something that was never there
F23 5o) need to speak more and open up	G23 5i) so difficult	T23 5c) 'so kan elke mens iets skep'
	G24 6d) All the crap trials around you.	
	H23 5f) indicates that storm reflects something of her life	
	H24 6h) disclosed very personal information which elicited distress	
	J20 2d)themes from music - ,2div) very bad	

Figure 2.4. Organising Level 1 codes into Level 2 codes

Step 4 – Organising level 2 codes into sub-themes

The level 2 codes were then organised into Level 3 codes (sub-themes). At this point the codes pertaining to musical descriptions were organised into one set of Level 3 codes (constituting musical content) and the two sets of Level 3 codes pertaining to verbal responses were combined and organised into a second set of Level 3 codes (constituting verbal content). This resulted in 25 level 3 codes (or sub-themes) for active music making and 53 level 3 codes (or sub-themes) for verbal responses.

Step 5 – Identifying themes

The final step was to further arrange the level 3 sub-themes into themes. Ten themes were identified from the Active Music Therapy codes and thirteen themes from the verbal responses sub-themes. Figure 2.5 illustrates a summary of the coding process and table 2.5 provides a summary of the five steps followed during the thematic analysis. The text in red indicates the theme 'Tensing and Un-tensing'. The theme comprises numerous level 3 codes (sub-themes) indicated by the blue text. Each level 3 code is allocated two columns. The column on the left lists the level 2 codes that comprise each sub theme. The column adjacent to that provides a breakdown of each Level 2 code with its corresponding level 1 codes. These level 1 codes direct the reader back to the raw data in the transcription of the music therapy sessions (see Appendix IV for an example of the full coding process).

Tensing and un-tensing			
References to physical bodily distress and ease	References to physical bodily distress and ease	Tiredness	Telling about being stressed and tensed
Active (VA92)	Active (VA92)	Tired (VA51)	Distressed response (VA112)
Sore (VA64)	N8 5y) I do something (when making music)	Tired (VR109)	Anxiety (VA46)
Muscle relaxation (VA21)	N12 5l) ja very nice, I exercise	Drained (VR110)	Anxiety (VR175)
Physical limitations (VA116)	Sore (VA64)	Lethargic (VA23)	Nervous (VA45)
Does not exercise (VA56)	B4 1l) comments on hands being sore at end		Nervous (VR76)
Reference to body (VA22)	D3 1t) Especially the head.		Stressed (VR19)
	D3 5b) My headache		Stress (VA07)
	D3 5m) not that bad, but		Tense (VR35)
	D8 5c) my head is burning.		Not calm (VR136)
	G2 2b) ow -referring to muscles		
	G12 5b) No, just painful.		
	H4 1e) complained of sore back		
	H3 7g) complains of headache		
	T4 4k) hands sore after playing		

Figure 2.5. Summary of coding process

Table 2.6. Five-step coding process

Step 5: Identifying Themes		
	Active music making	Verbal Responses
	10 Themes	13 Themes
Step 4: Level 3 coding (sub-themes)		
	Active music making	Verbal responses (RMT & AMT)
	25 Codes	53 Codes
Step 3: Level 2 coding (3 sets of data)		
Active music making	Verbal Responses (RMT)	Verbal Responses (AMT)
340 codes	214 codes	145 codes
Step 2: Segmenting the data (Level 1 codes) +- 8000 codes		
Step 1: Data transcription 42 000 words		

It is important to state at the stage of level 3 and 4 coding, identifying sub-themes and themes, that this was done as joint activity with the research supervisor so as to ensure optimal articulation and capturing of the meaning expressed by the lower level codes. The conjoint analysis afforded understanding that is not restricted to the music therapist's interpretation (since the supervisor is not a music therapist), but the identified themes being refracted through the lenses of the professional fields of both music therapy and mental health.

All the way, the analyses aimed to stay as close to the raw data as possible by ensuring that the higher level codes captured the essence of the codes at lower levels. Thus, the emerging themes from both data sets should represent as closely as possibly the salient aspects of the raw data. The verbal responses were verbatim accounts of clients' verbal utterances, whereas the musical content were captured descriptively by the therapist-researcher. It was important not to avert interpretation (adhering thus to the principle of bracketing) at this stage of the study (i.e. data collection) and deliberately postpone interpretation to the later stages of analysis, even though acknowledging that an experienced music therapist would inevitably use 'taken for granted' labels in describing musical content.

2.8. Trustworthiness

As data were generated from case studies of my personal interactive clinical work with participants, this research falls broadly into the category of participant-observer research. Also, participants reflected on the therapy process during and after the course of therapy, thus their being in the observer role too. Robson (1993) states that a key feature of participant observation is that the observer becomes part of the observed phenomenon. This can have implications for analysis if the researcher approaches the data primarily through the lens of their own subjective experience. Whilst the researcher's participation and subjective experience are inextricably linked to the research process, rigour, reflexivity and stewardship on the part of the researcher is required to ensure trustworthiness of the research.

Qualitative research is by its very nature subjective. This should not be regarded as 'bad science' when managed and regarded as a tool or resource in the process of research. Managing subjectivity and bias involves a) acknowledging and even exploring bias, b) regular supervision and peer debriefing, c) ensuring data triangulation and d) developing a self-reflexive, critical stance throughout the process (Ansdell and Pavlicevic, 2001). These are key components to ensuring the trustworthiness of the study. Lincoln and Guba (1985) refer to three criteria to determine the trustworthiness of qualitative research i.e. a) credibility, b) applicability and c) consistency (Lincoln and Guba, 1985: 290).

In the case of this research the principles of trustworthiness were addressed through a) the generation of substantial video and transcribed data which formed the basis of the in-depth thematic analysis, b) data triangulation which was addressed through i) the inclusion of audio and video examples and images

in the presentation of the findings to support what is described in written form and ii) the analysis of the post music therapy session in- depth interviews (guided by semi-structured schedule), by using another researcher who conducted the analysis independently of the data collection, d) conjoint working of researcher and supervisor on the thematic analysis, and e) by utilizing another music therapist who was not part of the research team to listen to the identified audio clips in order to verify congruence between the descriptions and the audio examples of musical content from the music therapy sessions.

2.9. Ethical considerations

The study was approved by the Faculty of Health Sciences Research Ethics Committee at the University of Pretoria (see Appendix V for Certificate of Ethics approval). Approval was also obtained from the PhD-committee of the School of Medicine. Permission to conduct the study at Weskoppies Psychiatric Hospital was obtained from the Chief Executive Officer of the hospital.

All participants were informed properly about this study and their voluntary written informed consent was obtained (see Appendix VI for the informed consent document that was approved by the Research Ethics Committee and used in the study). Participants were only enrolled in the study when they were assessed as capable of consenting to participation in research. The researcher consulted with the patient's clinical team to ensure this.

The research adhered to the most recent stipulations of the Declaration of Helsinki. Furthermore, it sought to adhere to the following considerations highlighted by the Department of Health:

2.9.1 Respect for dignity, safety and well-being of participants, ensuring that participants' rights are not threatened in any way;

2.9.2 Relevance of the research topic that it would benefit the broader diagnostic groups that these participants represent;

2.9.3 Scientific integrity ensuring that sound methodology and adherence to the research paradigm and design is rigorously observed;

2.9.4 Investigator competence wherein the researcher has relevant clinical experience with patients suffering from the two identified diagnostic groups and familiar with the clinical context having developed credibility in this field of music therapy practice;

2.9.5 Investigator responsibilities include the protocol to be observed as far as the University's

submission regulations are concerned;

2.9.6 Informed Consent to ensure that participants are adequately informed about all aspects of the research study.

2.9.7 Confidentiality to ensure that the participants' right to privacy and anonymity will be adhered to at all times, using an alias when referred to in case descriptions;

2.9.8 Publication of findings will be done through submission of articles to accredited journals in a competent manner;

2.9.9 Transcriptions of video, audio and written material will be safely stored with access by the researcher alone. This material will be stored for a period of 15 years.

2.10. Presenting the findings

Chapters 3 and 4 present the findings of the above described analysis. Chapter 3 presents the themes that emerged from the verbal responses of clients. These verbal responses were either elicited during active musical participation, through music listening techniques or in conversation preparing for or reflecting on different components of each session. Thirteen themes emerged during the data analysis and these will be demonstrated with quotes and descriptions from the data. Where applicable, audio and video excerpts are included in the discussion to illustrate examples from the data. Drawn and clay images as well as written text such as stories were elicited through music-centred listening techniques. Examples of these are presented in these chapters to support the written text. Quotes stated in Afrikaans are written in italics and the English translation is provided'. Included in this chapter are Comparative findings in which client response to the respective music therapy techniques are compared, as well as the response of the respective diagnostic groups. The final section of the chapter presents a table with the themes resulting from the independent analysis of the in-depth interviews at the conclusion of the music therapy process.

Chapter 3 provides the context of verbal affordances that are coupled with the findings reported in Chapter 4, being about the musical affordances. Chapter 4 presents the emerging themes from the Active Music Therapy component of the intervention. The findings do not present clients' engagement with Receptive Music Therapy separately as responses to receptive techniques were either verbal or creative (musical, image making or writing) and thus, were expressed in the themes reported in Chapter 3.

The ten themes that emerged during the analysis of the active music making of the music therapy sessions that included structured music-centred exercises and improvised music making in the form of instrumental improvisation, drumming, movement and singing. Clients' participation in active music making was transcribed, by the therapist-researcher, from the video footage of 131 sessions. Musical qualities described included tone pitch, timbre, dynamics, phrasing, melody, harmony, meter, rhythm and instrumentation. This applied to all aspects of music making within the session i.e. the client's music, the therapist's music and the joint music of client and therapist.

Included in this chapter are references to data descriptions as well as a range of audio and video excerpts which serve to support references to the written data. The audio and video clips are provided on the accompanying CD (see Appendix VIII).

In the case of both chapters 3 and 4, where there are numerous references within a specific sub-theme or theme, the most telling examples are quoted. When describing specific examples from the data the client and diagnostic group will be indicated as MDD- (Major Depressive Disorder: Clients A-J) and SS- (Schizophrenia-spectrum: Clients K-T). First level codes are indicated as e.g. C12 3a (Client C, column 12, Session 3, first code). Second level codes are prefixed with VA, VR or AM. These indicate verbal responses to Active Music Therapy (VA) and Receptive Music Therapy (VR) and active music making (AM) respectively.

2.11. Conclusion

This chapter has described the methodological aspects of the study including the premises and processes of this study. The steps are described that were taken to analyse the data generated during the music therapy sessions in addressing the objectives of the study, these are., to explore, describe and compare qualitative affordances of a music therapy intervention comprising Active Music Therapy (AMT) and Receptive Music Therapy (RMT) techniques, respectively and in combination, among patients suffering from major depressive disorder and schizophrenia-spectrum psychotic disorders. The next two chapters present the findings of this analysis, both describing and comparing verbal and musical affordances in respect of music therapy techniques and diagnostic groups respectively.

Chapter 3: Verbal affordances

This chapter presents the themes that emerged through the verbal responses of clients. These verbal responses were elicited during active musical participation, through music listening techniques or in conversation preparing for or reflecting on different components of each session.

3.1. Introduction

The data analysis yielded thirteen themes that will be presented with reference to verbatim quotes and descriptions from the data. Where applicable, audio excerpts or images will be included in the discussion to illustrate and support examples from the data. Images refer to clay images, drawings and written texts such as stories which were elicited through music-centred techniques. Quotes stated in Afrikaans are written in italics and the English translation is provided'. Included in this chapter are Comparative findings in which client response to the respective music therapy techniques are compared, as well as the response of the respective diagnostic groups. The final section of the chapter presents a table with the themes from the independent analysis of the in-depth interviews at the conclusion of the music therapy process.

Where there are numerous references within a specific sub-theme or theme, most telling examples are quoted. When describing specific examples from the data the client and diagnostic group will be indicated as MDD- (Major Depressive Disorder: Clients A-J) and SS- (Schizophrenia-spectrum: Clients K-T). First level codes are indicated as e.g. C12 3a (Client C, column 12, Session 3, first code). Second level codes are prefixed with VA, VR or AM. These indicate verbal responses to Active Music Therapy (VA) and Receptive Music Therapy (VR) and Active Music making (AM) respectively.

Table 3.1. Themes – verbal affordances

Themes	Subthemes	Salient examples
Not to feel	**Indifference**	*'lack of willingness' (B19 1ik)* *"the usual pattern would be to stay in bed"' (I25 7ak)*
	Not feeling	*'it's dead', 'I don't feel like nothing', 'I'm not feeling anything right now' (R20 2c, 2c, 2h)*
	Suppression of the unbearable	*'I don't like to feel emotions' (I21 3d),* *'I don't even want to look at it' (I21 3j).* *'you want to cry, but you can't', 'heart full of tears but can't cry' (L19 1d, 1g).*
	The issue of feeling and facing emotions	*Look it squarely in the eye.. Sadness, disappointment, regret ..just some of the emotions I keep , that I bottle up, so I want it to be out in the open and I want to stare it out' (I25 7h)*
To do or not to do	**About who begins**	*'why must I start?' (F3 6a)* *'you can go all the time. I'll follow you' (R14 4a)*
	Resisting doing	*'it's not my thing but let's go on', 'I don't like this (vocal)' (R15 1d, 1i)*
	Stuck	*'I'm stuck' (P8 7l)* *'I feel blocked. I don't know' (P8 7t).*
	Failing, also in self-confidence	*'Nice. But I need more confidence'*

		(F15 5p) *'I am too shy and I'm not very good' (T15 1f, T3 2l).*
	Willingness to venture	*'I haven't got a cooking clue about music but I tried' (G8 4v)* *"coming out of my cocoon' (E24 6k), 'getting out of my safe space' (E25 7ac)*
	The making of a decision	*'Undecided, I'm confused, unsure, demotivated' (F26 8b)* *'at a crossroad in daily life. I need to make a decision… Stick with what I've decided. Having as much support around me. I'm not going back' (G26, 8 d-q).*
Grappling with the desired future	**Ending it through suicide**	*'It's sadness that pushes you to the edge and want you to escape to somewhere, where you will feel at peace, or end it all' 'there was a time when I wish I was,,yes…' (A20 2o)*
	Doubt and skepticism about the future	*'I don't know if I'll ever, I don't know when I will ever be to there, I tried a lot' (A20, referred to in 2t)* *..if it's not real then there's no point' (B19 1x,y)*
	An impasse, with unwanted dependency	*I feel angry in myself, I feel dependent, sometimes lonely and unhappy' (F25 referred to in 7e, 7v)* *I can't comfort myself, I need someone to comfort me' (J20 2n)*

	Escaping from the realities of life to some ideal situation	*'It is a place I wanna be, no stress no pain, no suffering, not waking to a day when you feel it should never be. A sense where there is love laughter, a place where everybody would like to be"(A19, session 1)* *'from loneliness and torment to happiness and feeling content' (I23 5c)*
	Envisaging a desired future	*'Yes,, I can glimpse a step because I'm looking forward to um to being trained by Yesne so that I can get the skills on how to run financials and stuff like this' (A23, session 5)*
	Aspiring towards financial and occupational independence	*I would like to support my mom more. Get a job, obviously to support her (F22 4t)*
Hurt and fear of undesirable outcomes	**Disabling impact of trauma**	*'it just hurts so much more because I was a child' (I22 4af)* *Then also a bit of fear and the unknown, and that's a big problem after the two hijackings and the burglary. I always used to check everything six or seven times before I got into bed. Always felt uncomfortable, won't drive certain areas because it's too dangerous, totally changed my life. I will never drive in the area. I will never go*

		there again.' (G21 3k, 3t)
	3. Ominous anticipation of the unknown	*'I don't really know what's going to happen there, because it can change anytime' (A20 2r).* *'It relates to the fact that while I'm still waiting for the unknown I can have my peace … I don't know what will happen. I cannot control it, I cannot change it. I have to wait and see. It develops emotions of uncertainty because you don't know what is coming (P21 3e, 3i*
	Fear of hurt and the unknown	*'I feel scared and lonely' (E25 7i).* *'Scared, it's a challenge, but I must do it. Other people have also done it. I don't know if I will get it right because I have not yet flown' (T25 7m).*
Sadness, brokenness and futility	**Telling about sadness**	*'my heart was very sore, very red inside, I know I'm heartbroken' (J24 6e)* *'Sadness, ag it's just you live with these anxieties, you don't realise nature anymore…So much lost time,' cause if you so depressed that you don't want to let people see how you actually are, because you are putting up a front for people', (G19 1d)*
	Brokenness	*'something broke me – from there*

		it went down' (B19 1i) *I feel like everyone is smashing me (E22 4h)*
	Hardship and struggle	*'The worst journey to be endured' (A23 5c)* *so difficult', 'all the crap trials around you', 'felt like this forever' (G23 5i, G24 6d, B19 1h)*
	Feelings of futility	*'feel hopeless, on my knees, can't stand up' (A20 2p)* *'I've tried too many times' (G23 5g),* *'I thought I was useless', I'm useless' (J21 3h; J19 1g)*
Anger, trust and vulnerability	**Intimate vulnerability**	*To tell you the truth I'm so scared of being hurt, the stage I am I'm vulnerable' (A21 3an)*
	Anger at others and self	*'I'm feeling very angry, I'm still angry' (A24 6i, 6r, 6u)* *'I hate my dad, because he did…'(D19 1k)*
	Difficulty in trusting others	*'don't trust people that much' (E23 5n)* *'I think I should put my trust in, even if it's one person at a time' (I25 7ai*
Desire for connection and affection of others	**Loneliness and isolation**	*'I feel like I'm alone now',' no one is there for me', 'I can't, cause I'm all alone' (D20 2j, D22 4c, 4j)* *I am alone with my problems (M26 8e)*

	Loss of self and others	*'What's past is past. I can't bring them back. With my husband the past is past.' (J25 7o)* *'It was very bad, growing up without my father. I didn't know him (J257k)*
	Need for social connection	*' I need someone to help me' (D22 4o)* *' I need someone to share my feelings, because it builds up', 'I need the support wherever' (F26 8n, 8o)*
	Desire for intimacy and love	*I need someone to comfort me, telling me they love me' (J20 2k* *I have this longing to be loved again' (G257t)*
Barricaded from being present, now	**Difficulty being here, now in music making**	*'I can't think too much. If I think too much and concentrate hard I get a headache' (T17 1h).* *'something's going on with my mind', 'just that my mind, eish' (D2 1l)*
	Forgetting and remembering	*'all the songs have gone out of my head' (P10 3d)* *'I can't remember. Is it with music or without music' (T3 6a)*
Tensing and un-tensing	**References to physical bodily distress and ease**	*'My neck eish'' especially the head', 'my headache', 'my head is burning' (D3 1t D8 5c) (D2 5a),* *'yes, but more on my neck and shoulders and in my back', 'a little*

		bit tiring in the back but it's ok' (G2 2b, G2 1f, G12 5m), *'very nice to bend down, yes.', 'Yes I feel it' (J14 3f, J12 6h)*
	Tiredness	*'yes I had to go on, no matter what, no matter how I tired I am' (A8 2l)* *'that feeling of being drained' (B19 1f*
	Telling about being stressed and tensed	*'I'm feeling stressed, that's why I came to hospital' and 'I was very stressed when I came here' (J19 1e,1m),* *'Horrible, like I have no control in that space', 'affects my speech' (I20 2h, 2i)*
	Calming	*'because I don't breathe deeply – I must learn to breathe deeply' (F2 2i* *'a bit calming considering what I've been through these two days' (A8 6ao), 'I'm feeling more calm, yes' (A11 6r)*
Relating to one's musical expression	**Non - acquaintance and novelty of music making**	*'I haven't got a cooking clue about music but I tried' (G8 4v)* *'stupid' with music' (R8 5d)* *'something new', 'easier but still a new experience', 'something new for me' (F14 2j, F5 3z, F12 6g)*

	Reconnecting with previous musical experience	*'I love it', 'out of practice', 'good to play again',' my fingers don't work so well' (F16 3r, F15 4l, F15 4m, F15 5l).* *'been out of it for so long' (F24 6m).*
	Personal identification with music preferences and familiarity with musical expression	*'I don't like jazz, because it makes me think, think, think' (D15 1b),* *'Neo. The old, not his new stuff. Adele, yes, everything' (I12 1b),* *'mostly I like to sing gospel songs' (P16 1a),*
	Exercising choice in music making	*'definitely drums. Something that can make a noise' (F11 7i)* *chooses rain stick for 'Challenges' theme –'irritating sound' (P11 7c)*
	Discomfort with own voice in singing	*'no not my voice', I'm thinking I would rather do it on the piano', 'Ag no. I hate it.', I'm actually scared of my voice. Don't know why?'(F15 1p, F17 1c, F15 2a, F15 2i, F5 3u, F15 5i, F15 2t)*
Reflections on the music and music making in therapy	**Spontaneous commenting on music making**	*'should be very slow..something soft' (A11 1b)* *'I will start with this just to hear what you are playing' (F8 3d)* *'can I say the words and not sing' (I8 8b)*
	Heightened awareness and appreciation of music	*'Misty. Yes of course. Beautiful, I love it' (F2 5g)*

		'oh we make the music louder and louder' (J11 3f) *'I realise it has different sounds' (P8 1j),*
	Recalling significant life-event memories	*' if she were still alive I would not be here' (D20 2aa)* *'I remember that day, I will not forget it' (D23 5e)* *I'm telling you something very personal (T3 1j)*
	Metaphorical reflections on affordances and connections brought about by the music therapy	*'The door is rusted but I pushed it to open it bit by bit' (A25 7g)* *'The mamma fish and the baby, I have to be exposed to other things that are difficult and I have to be strong, yes, like a mamma fish (A24 6ao)* *'I want to grow up like a tree'(O20 2h, O21 3d*
Resilience in courage	**Accepting circumstance and events**	*attempt 'to accept what happened' (E24 6f)* *' when we accept there come tears of joy again(J8 5i),*
	Change for the better	*'I remember the first day and thinking how is it going to help me, yes I was so negative. But I said to myself let me give it a try. I woke up emotionally. '(A11 7w).* *'mind closed now open, eyes closed, now can see', 'I don't think now to commit suicide again' (J24*

		6c-6k)
	Strength and courage	*'it made me very strong, yes I'm strong. I can face everything' (J12 6g),* *'forward I go, stronger, stronger, and I will win' (A18 8g)*
	Growing motivation in goal setting	*'I want to go to another level' (D22 4n)* *'first step is to know the skills' (A23 5ac)* *'I was thinking of giving clarinet lessons for young people' (F24 6r),*
	Persisting forward	*'Even though I will fall, I will stand up and move on' (A26 8t).* *'I have to break the barrier piece by piece'(I23 5p)*
	Attributing personal virtues	*Ek's nie 'n niks – I mean something to myself, I am not a nothing' (T8 1q, T26 8m).* *'other part of self revealed and 'never knew there is that person in me' (A23 5ae, 5ah, 5ar).* *'I'm proud because I didn't play this before' (D8 5y)*
Invigoration and Liberation	**Experiencing music as pleasurable**	*'wow, this is so nice. Brings it out in such a subtle, calm way' (I11 4k)* *'ek is mal oor hierdie musiek – I am mad about this music' (S16 1g)* *'very nice. Good music' (N8 3k)*

	Expressions of joy	*'it puts you in a different space which is absolutely fun which I haven't had for a long time' (G8 4w, 4x)* *'it was fantastic. You can dance with your feet and with the movement' (L14 3k)*
	Liberation	*'Yes, I felt liberated, feel that I can do anything that I..' (A4 1m, 1n)* *' I experience that I become, I take a deep breath, feel release' (J11 3j)* *'free, go on the wind and be free' (R19 1f)*
	Energising to life	*' I feel alive' (D12 1j)* *'it energises me (dancing)' (P13 8f)* *'I don't know what tomorrow is having for me. I don't want to think about tomorrow. As long as I got life' (J25 7n).*

3.2. Theme 1 – Not to feel

This theme is expressed through four sub-themes, all related to the central notion of difficulties regarding expressing and feeling emotions. These sub- themes refer to i) indifference, ii) not feeling, iii) suppression of the unbearable and iv) the issue of feeling and facing emotion

3.2.1. Indifference (VA05, VA93) (VR107, VR115)

Feelings of indifference were expressed, under various circumstances during the music therapy sessions. Examples from the data include: - referring to a life-altering incident the client indicated a "lack of willingness" (B19 1ik), "the usual pattern would be to stay in bed" (I25 7ak), "must I really draw?" (S24 6b) Other examples from the data include: - "it didn't bother me" (K19 1e), "the music sounds alright"

(N19 1d), negative in the beginning of the process (A11 7v). Of the music, after drumming it was said: "makes me think negative things" (D4 1n), with regard to aspects of music making indifference expressed about the positioning of the drum (H3 3a), the choice of which drum to play (R3 2a) and when asked how she responded to the movement exercise she said "I don't know what to say" (R14 3f).

3.2.2. Not feeling (VA02, VA99, VA128) (VR114, VR144, VR193)

References to not feeling' include: "a lack of everything" and "everything just stopped" (B19, 1j, 1l), "feels like nothing" when she is not understood' (L20 2t), 'it's dead', "I don't feel like nothing", "I'm not feeling anything right now" (R20 2c, 2c, 2h), "I'm like, this is ok, but I'm dying inside" (G19 1j) and Client H expressed feeling "dead"(H26 8aiii).

Feelings of emptiness were expressed: "the black represents the emptiness I feel sometimes" (E20 2o), "empty, hollow, needs something inside" (F22 4c, 4f), "ag this is just how I feel. Feel empty, unfulfilled" (F25 7t), "I feel empty, scared" (H24, 6f. H26 8aii).

Client P found difficulty relating how she felt after musical participation: "one word? I don't have a word", "we were just doing music, I don't have a feeling" (P8, 6j).

Responses that indicated blunted affect or ambivalence were present during Active Music Therapy techniques: "nice" (E2 4k, E12, 4n), "cause I don't know, I like it" (E3 8s), "anything. You choose the song, just give me chords" (F15 4c). Client S after the first drumming activity lost interest and requested to do something else. She also showed ambivalence about suggesting ideas for the relaxation component in session 5 (S3 1j, S2 5a).

3.2.3. Suppression of the unbearable (VR137, VR151, VR 153, VR154, VR155, VR184, VR207)

The following responses were all elicited by Receptive Music Therapy techniques. Firstly, clients referred to difficulty in accessing and feeling emotions: Client E acknowledged that before admission to hospital she had difficulty accessing feelings (E21 3n) and, in a later session, said that she recognised the need to communicate feelings (E24 6o). Client I, in the first session said she is "afraid to feel emotion" and that she "blocks emotions" (I19 1h, 1j), in session 3 said, "I don't like to feel emotions" (I21 3d), She drew an image of a whirlwind of emotions (Image 3.1) and said "I don't even want to look at it" (I21 3j). In session 4 she said that she is "afraid of facing emotions" (I22 4w) and said "That's why I never dealt with my issues from child" (I22 4ad), in session 5 she spoke about putting her "emotions in a bottle" (I23 5o)

and in session 7 referred to being a "prisoner to emotions" (I25 7i).

Secondly, clients reflected on having suppressed feelings : "So now I have suppressed quite a few" (I21 3e), "blocking me from reality" (I25 7j), "*miskien hou ek baie dinge in my wat ek nie uitgee nie, dit is binne, dit wil nie uitkom nie* – maybe I keep things in me that I don't let out, it won't come out", "it's difficult I don't let it out" (F23 5m, 5q), "people not seeing depression", "tired of putting up a front" (G19 1g, 1h), " you want to cry, but you can't", "heart full of tears but can't cry" (L19 1d, 1g).

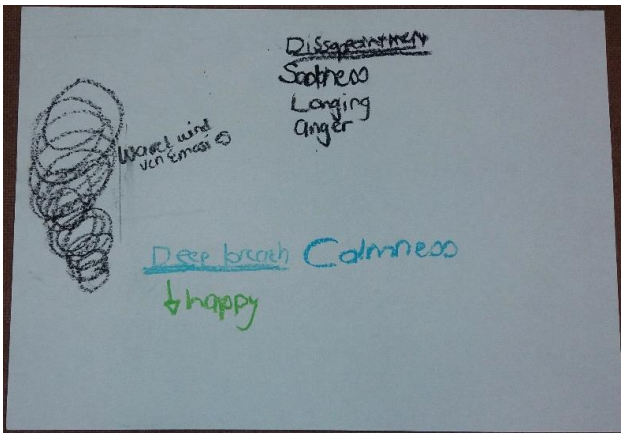

Image 3.1. (Client I - MDD, Session 3 – Whirlwind of emotions)

Thirdly, clients related feeling overcome by difficult feelings: Client I, as in Image 3.1, referred to a "whirlwind of emotions", where the "hard emotions overpowered calmness" and compare the whirlwind to a dark cloud" (I21 3g, 5f, 5g), she spoke of "isolation – need to learn to communicate feelings" (I25 7m). Client H, in session 6 was reminded, through the music, of personal associations. During disclosure of this aspect of her story, feelings of distress were elicited (H24 6h). Client M, reflecting on loss said: "I'll feel bad. Lost my lady" (M23 5f). Client P (SS) reflecting on her feelings around loss of control stated "it develops emotions of uncertainty" (P21 3l).

3.2.4. The issue of feeling and facing emotions (VA129), (VR106, VR125, VR152, VR155, VR169, VR180, VR203)

Both Active Music Therapy and receptive techniques elicited a range of emotional responses through imagery, symbolic material, verbal reflection or active participation in music making. These responses

referred to a range of feeling states, the co-existence of contrasting feelings and facing emotions. Client F, in session 2, used colours to represent different aspects of self as he listened to short excerpts of contrasting pieces of music (Image 3.2). The image represents numerous feeling states. The client referred to the black shading as 'anxious, heavy, moody, and vicious' and the pink as 'opposite - More relaxing, forgiving, acceptance' (F20 2k).

Image 3.2. (Client F - MDD), Session 2 – Feeling different emotions)

In reflecting on this the client said "I can be this or this, depends on". He was referring to the fact that he experiences both the feeling states that the black and pink colours represent, although his current dominant feeling state was represented by the black. (F20 2k).

Other responses include: "*partykeer voel ek harseer, partykeer bly* – sometimes I feel heart sore, sometimes happy" (H20 2i). Client P referred to an earlier session which had resulted in dialoguing between two images she drew, a rainbow and storm. She said "You will never be 100% in the sunshine with no rain" (P26 8q). Client S, having drawn a "smiley face" to whom she assigned a character (Jordan), used the image as a means to engage with her own difficult feelings. The client was invited to dialogue with the character:

> Dialogue: "*Ek wil nie meer hier wees nie,* hoekom nie, waar wil jy dan wees*? Ek wil graag by die huis wees by my ma en ouma wat vir my omgee*. Maar dis mos nie so ver nie. *Yes dit is, jy verstaan nie wat aangaan nie.* Nou, vertel my bietjie meer. *Dinge is te veel, hierso wil ek nie meer wees nie. Ek wil graag by die huis wees.* Nou wat moet ek doen om jou te kan help?
>
> *I don't want to be here anymore*, why not, where do you want to be? *I want to be at home with my mother and grandmother who care for me,* But that's not so far. *You don't understand what's going on.* Now tell me a little more. *Things are too much, I don't want to be here*

anymore. I want to go home. Now what can I do to help?" (S24 6m)

This dialogue enabled the client to give expression to her feelings of frustration on the ward, of missing home and of finding daily existence difficult.

In session 4 Client T was invited to create something out clay to represent how he feels. He created a "goldfish" (Image 3.3).

Image 3.3. (Client T - SS, Session 4 - Step 1 clay process)

Upon reflection the client stated:

> *"Ek is 'n Pisces, ek dink ek's soos 'n goudvissie. Ek kan maklik seer kry, voel amper vir my, ek weet ek's nie die belangrikste in die wereld nie, maar soos met die musiek ek kon 'n haai gemaak het of so iets, ek is so gevaarlik soos 'n haai, en ook so sag soos 'n goudvissie,…, 'n mens moet baie versigtig wees hoe jy 'n Pisces hanteer, want hy kan baie gevaarlik wees, baie sag wees, hy kan baie hard wees, delikaat*.
>
> " I am a Pisces, I think I'm like a goldfish. I can easily get hurt, feels almost like, I know I'm not the most important in the world, but with the music I could have made a shark – I am as dangerous as a shark, but also as soft as a goldfish, people must be careful how they handle a Pisces because he can be very dangerous, very soft, very hard, very delicate" (T22 4g).

Through this process the client acknowledged the hurting part of self, whilst also referring to an aspect of self which is potentially destructive. Some images elicited in the music assisted clients to reflect on facing difficult emotions. Client I in session 7 drew an image which contained a figure at the top of the steps, a picture frame of emotions and an empty bottle'. She reflected thus:

"This is where I want to be. The steps, I've reached the top and it's kind of a "come" (raises arms). This is the bottle. A bottle of my emotions. It's empty. I want it to be empty. The emotions out in the open. In Afrikaans there's this saying "Staar jou probleem vierkantig" Look it squarely in the eye..Sadness, disappointment, regret..just some of the emotions I keep , that I bottle up, so I want it to be out in the open and I want to stare it out" (I25 7h)

Whilst this theme concluded with reference to a client's acknowledgement of the need to face and deal with her emotions, she, like many clients experienced the difficulties, the not feeling and the suppression of feelings more keenly than acknowledging feelings, accepting the co-existence of contrasting emotions and being able to deal with or face unbearable feelings. Most responses in this theme refer to receptive techniques, both diagnostic groups were referred to throughout the discussion.

3.2.5. Comparative findings – Theme 1 (Not to feel):

Table 3.2 illustrates the ways in which the respective music therapy techniques elicited responses of indifference, ambivalence or difficulty in feeling and expressing emotions. Active Music Therapy techniques seemed to elicit responses about their experience of the music, whereas Receptive Music Therapy techniques elicited responses concerning clients' internal states of feeling that ranged from feelings of nothingness to the awareness of suppressing feelings.

Regarding the theme not to feel, table 3.3 differentiates between the diagnostic groups. Clients from both diagnostic groups indicated indifference and were able to articulate feelings and used symbolic material to do so, but clients from the MDD-group more readily articulated inner states of feeling and displayed awareness of feelings, and the facing and suppression of emotions, whereas among clients in the SS-group difficulty was experienced in the awareness and the articulation of feelings.

Table 3.2: Comparison of music therapy techniques – Theme 1

Responses elicited by Active Music Therapy techniques	**Responses elicited by Receptive Music Therapy techniques**
Drumming associated with negative thoughts Ambivalence about participation in active music making/ choice of instrument /choice of music	Feelings of 'nothingness", dead, dying inside" Being afraid to feel emotion or difficulty accessing emotion

Indifference about feelings after music making	Insight about suppression of feelings Becoming aware of range of feelings Contrasting music offers alternate feeling states Experiencing feelings as overwhelming Music, words, image and dialogue opens up emotional expression , offers problem solving Accessing different parts of self New realisations

Table 3.3: Comparison of diagnostic groups – Theme 1

Major Depressive Disorder	**Schizophrenia-spectrum**
Recalls past significant moment with regard to feelings of indifference Reflection on drumming associated with negative feelings Articulate specific feeling states Indifference expressed with regard to music making Articulated fear of feeling Articulated need to face emotion Referred to suppression of emotions Reflect on feeling contrasting emotions	Indifference with regard to musical participation Difficulty reflecting Difficulty finding vocabulary Articulates specific feeling Expresses restlessness Refers to past relationship with reference to feeling bad Expresses feeling out of control Connects own feelings with projective dialogue technique Uses symbolic material to express own feelings

3.3. Theme 2 - To do or not to do

Whilst theme 1 had to do with 'feeling', theme 2 has to do with 'doing'. This will be discussed with reference to clients' responses to active music making as well as responses elicited by music listening. This theme will focus on i) about who begins, ii) resisting doing, iii) stuck, iv) failing, also in self-confidence, v) willingness to venture and vi) decision making.

3.3.1. About who begins? (VA28, VA32, VA41, VA42, VA43)

This sub-theme relates exclusively to the Active Music Therapy component of the intervention and has to do with client responses when invited to initiate, lead or make choices within music making. The data indicate that in earlier sessions clients seemed hesitant to start or lead. Examples from the data include – "no start please" (A4 1c), "please start" (A17 1c), "eish can you please play one more" (D6 2x), "can you please start" (D8 3c), "rather you sing" (F15 1k), "why must I start?" (F3 6a), "you can start" (L15 1a), "I will follow you today" (R8 3a), "you can go all the time. I'll follow you" (R14 4a). This hesitancy to take musical initiative may be due to various reasons, including the novelty of music therapy sessions, being unfamiliar with playing music, feelings of uncertainty or low confidence levels. These references to the data were from sessions 1-4.

As the music therapy sessions progressed this pattern changed. Clients began to either exercise more initiative by seeking clarification or by directing the therapist during musical tasks. Examples where clients sought clarity include: - client asks whether she can play "anything" (A3 2d, E18 8d), "we follow each other?" (A3 3d), "Must I give a rhythm?" (F3 4a), "so I must reply when you finish" (R17 1b), "*wat moet ek doen?* – what must I do?" (T14 3b).

The data also illustrate instances where clients exercised choice and initiative during music making. Examples from the data refer to clients" selecting which instrument the therapist should play, how the music should proceed and on one occasion correcting the therapist when she did not mirror the client's rhythm correctly: - "you play the piano" (A11 1c), "will you play the guitar?") D16 3d), "you must start and I will follow you" (F3 6b), selects piano for therapist (S11 7d), during a mirroring exercise the therapist did not mirror the client's rhythm accurately – the client said "not exactly" (D6 2q) and demonstrated the rhythm to the therapist for a second time.

Whilst this sub theme did not apply to all clients, it illustrates musical and personal uncertainties and inertia with regard to musical initiative and action.

3.3.2. Resisting doing (VA16, VA54) (VR150)

This sub theme demonstrates a few instances where clients indicated resistance within active music making. In the case of Client R this referred to sessions 1 and 2 "it's not my thing but let's go on", "I don't like this (vocal)", "don't feel like changing nothing", "I don't feel like playing, I don't have the power" (R15 1d, 1i, R3 2b, R20 2m, R224l). In referring to her diagnosis and admission to hospital Client R stated "don't want to listen to anybody" (R20 2m), Client S, in session 1, indicated that she did not enjoy the drum (S4 1g) and then lost interest saying that she would enjoy something else (S4 1h). In session 4 she was called out of the session to the doctor. Upon her return she did not want to continue due to feelings of irritation.

Whilst the data indicate resistance to aspects of musical participation, this may also indicate clients' agency through the articulation of preference, choice and feelings.

3.3.3. Stuck (VA48, VA49, VA70, VA71) (VR32, VR116, VR128, VR129, VR177)

With reference to music making clients expressed feeling stuck, unable to shift or change aspects of musical expression: "I'm stuck" (P8 7l), "I feel blocked. I don't know" (P8 7t), "You know what, today it's like I can't", "No I can't use, how can I say, I change from one" (A83p,3q), "I've always got only that one, *ek net daardie een in my kop wat ek altyd spee* – I've only got that one in my head that I always play". With reference to verbal expression: "I don't know how to express it, I can't express it (B19 1o).

This sub-theme also reflects experiences of feeling stuck at a more personal level. The data refer to varied responses, some linked directly to the experience of clients, while others are projective responses as clients engaged with symbolic material elicited through music-centred techniques: "so dark can't rise up" (A21 3e), "*n gat en dis swart* – a hole and it's black" (H26 8b), "*donker gat* – dark hole" (H26 8c), "this one wouldn't know how to get from there to there" (B19 1ad), "*Vasgesluit. Ek voel vasgekeur. Ek weet nie watter kant toe nie* – Locked up. I feel trapped – I don't know which way to go" (S21 3k,l,m). Referring to a clay image of a disabled man: "*Hy voel vasgekeur, hy wil uit sy situasie uitkom. Hy voel asof hy nerens kan heen gaan nie , niemand hom wil he nie* – he feels trapped, he wants to get out of his situation. He feels as if there is nowhere for him to go. Nobody wants him" (S22 4 d,e,g),"alone, isolated, disconnected, anxious, tense (F26 8f) and "Very frustrated. I'm in a situation I can't come out of. It's very hard" (R2 2d,e).

These utterances of feeling stuck within music making, verbal expression and related to personal circumstances affect clients' capacity to do, to take action, to change. The feeling state or circumstances may be experienced as overwhelming and as outweighing inner personal resources necessary to effect change. This is discussed in greater detail in 3.4.

3.3.4. Failing, also in self-confidence (VA29, VA44, VA69) (VR55, VR72, VR73, VR187, VR189, VR190)

With regard to personal circumstances as well as varied aspects of the music therapy sessions, clients indicated feelings of inadequacy and low self-confidence, hesitancy and reticence to try, difficulty accessing ideas or understanding instructions and feelings of failure and defeat. Examples from the data include: "I have two right legs" (A12 1a), expresses lack of ability to draw (A19 1c), "no, not my voice", agrees reluctantly to voice work, after an improvisation on the piano which highlighted his musicality he said "I can't play" (F8 5p), "Nice. But I need more confidence" and in session 6 referred to feeling shy. (F15 5p, F12 6h), "*ek sal nie se ek is talentvol nie; ek het nie 'n mooi stem nie* – I would not say I am talented, I don't have a good voice (H20 2g, H15 2a), "I'm not good at drums" (R3 5e) and "*ek is te skaam, ek is nie baie goed* – I am too shy, I'm not very good" (T15 1f, T3 2l).

Many clients when asked for musical ideas responded with "I don't know what/how" (H20 2g, B11 1f, D3 1n, D6 2f D6 2w, D15 2b, D8 3z,D14 3k, D16 3c, D15 4c, D8 5e, E11, M5 2c, N14 2i, N16 7a, N18 8c, O4 1a, P10 3f, P117i, Q8 1f, R3 5b, S5 3a, T6 2c), "don't know what kind of a story" (M235a), "I don't understand, what can I write?, what can I draw?" (N23 5c, d; N24 6b).

Client J referred to the perception of others with regard to her voice "they laugh at me, say I'm talking not singing, they say I don't have a beautiful voice. They say I'm just talking" (J15 1k, 2h).

Client A, with reference to personal circumstances said:

> "*I've been fighting, sadness, and I don't know if I'll ever, I don't know when I will ever be to there, I tried a lot"* (A20 2v),

In session 3, said this as she reflected on an image representing a range of emotions elicited by the music (Image 3.4):

> *"Um, sometimes it's so dark you feel you can't rise up and go outside um and just smell the fresh*

air, and then the times you go Oh My God, being scared, um yes it's dark and all that, not going to see the light, um and I'm so scared, um and then just let go of your feelings the way you scared, um then you go outside..just be careful, this ones are for easy going, just go with the flow, no matter what it is, no matter what's happening in your life, just ignore whatever bad things and concentrate on things, even though it's not much but just keep on going so that you can't fall and step into the darkness" (A21, session 3)

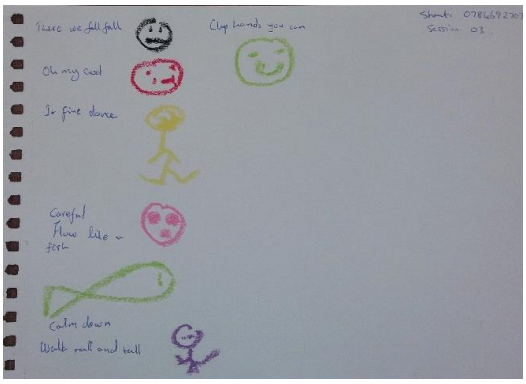

Image 3.4. (Client A - MDD), Session 3 – Range of emotions)

Client D speaks about her attempts to change:
"I've been trying to get some help. Even here, I feel I am wasting my time,… that's a hard place to be because you feel very stuck, you feel that there's no movement anywhere" (D20, session 2).

3.3.5. Willingness to venture (VA30, VA100) (VR68, VR93)

This sub-theme refers to clients who displayed capacity to break the impasse alluded to in the previous sub-theme. Firstly within active music making, clients demonstrated willingness to attempt active musical participation:-willing to try vocal work with song that suits his voice (F152t), tried to think of a song (G3 1g), "I haven't got a cooking clue about music but I tried" (G8 4v), "yes we can try that" (R14 2c), "Ok, we tried" (R8 3g).

Secondly, the following data references capture statements regarding attempts or intention to break circumstantial and emotional inertia. These responses were elicited through the music listening techniques and improvisations based on themes emerging from verbal reflections. Examples from the

data include: - “forward I go, stronger, stronger, and I will win” (A18 8k), “I must get to a stage in my life where I can say let it be”, (G107h), “considering going back to work” (I12 6h), envisages dancing with daughter (I12 7g), “Yes. I must just put my mind to it” (F22 4u), “I want to tell people my story” (E22 4m), “coming out of my cocoon” (E24 6k), “getting out of my safe space” (E25 7ac),”need to speak more and open up” (F23 5o), “I want to do things I want to do or can do” (F25 7t), “learn to do things differently” (I26 8e), “I don’t feel helpless” (J25 7i).

Client R’s seventh session coincided with the day she was discharged. She acknowledged the session as a preparation for going home. (R2 7b).

Client S said “*ek moet vashou, aanhou en glo* –I must hold on and believe” (S11 7l). She had been moved from the security ward to an open ward towards the end of the music therapy process. Although she found the adjustment difficult she indicated her intention to befriend patients on the new ward (S26 8j).

Client T: “*kyk vorentoe, kyk op, sprei jou vlerke en vlieg* – look forward, look up, spread your wings and fly” (T11 7m).

These are statements of action or intention ‘to do’. It is noteworthy that these statements were made in the later sessions (in general from session 5-8) and were representative of both diagnostic groups, although clients from MDD were in the majority.

3.3.6. The making of a decision (VR67)

> *“Yes but there are personal things, having a boyfriend, having a husband, having a children. I feel like I have been robbed of all of that. The third year when I was diagnosed, it's like everything is over, that's when I start making decisions in life that I won't have a baby, I can't be in and out of hospital and my kid is crying, for a husband too”* (Client A, session 3: A21 3ah).

Several facets related to the issue of decision making are expressed in this sub-theme. ‘To do’ and ‘not to do’ are both reflected in the data references. In the above quote Client A refers to the life changing impact of her mental health diagnosis, in many ways causing her to make ‘not to do’ decisions.

Other data references include: “Undecided, I'm confused, unsure, demotivated” (F26 8b),”at a crossroad

in daily life. I need to make a decision". With reference to an image representing a crossroad: "No regrets, left turn" and then said: "Stick with what I've decided. Having as much support around me. I'm not going back" (G26, 8d,l,m,o,q).

Client R commented on decisions made on her behalf "People trying to rule other people's lives and make wrong decision about them as if they have no right to do so, and it is not so… It's just that people make decisions about you and they carry on. I feel I don't belong here." (R25, f,o).

These references highlight feelings of being robbed of the capacity to make life choices, disempowered through the decisions of others, undecided in current circumstances and desired intention with regard to making a decision in order to move forward.

3.3.7. Comparative findings – Theme 2 (To do or not to do)

Both Active and Receptive Music Therapy techniques contributed to the 'not to do' part of Theme 2 through 'stuckness'. In the case of Active Music Therapy 'stuckness' was evident through perseverative musical expression and difficulty in varying aspects of musical material, whereas Receptive Music Therapy seemed to elicit feelings of 'stuckness' concerning clients' internal states and circumstances. Receptive Music Therapy, though, also seemed to elicit increased internal motivation and movement towards action.

Clients from both diagnostic expressed feeling stuck within music making and were dismissive of their own musical ability. Clients from both diagnostic groups also expressed a loss of agency with regard to the making of a decision on the one hand but stating an intention to move forward, on the other. Not being able to move and being in darkness were expressed in the MDD-group whilst loss of interest, feelings of isolation, resistance and frustration were prevalent within the SS-group

Table 3.4: Comparison of music therapy techniques – Theme 2

Responses elicited by Active Music Therapy techniques	**Responses elicited by Receptive Music Therapy techniques**
Difficulty shifting perseveration	Feelings of being trapped
Being stuck	association with darkness, no way out
Difficulty accessing new musical ideas	Associations with imagery
Dependent on therapist	Questions whether change is possible
Difficulty expressing initiative	Personal stuckness due to fear
Difficulty varying musical material	Feelings of hopelessness
Feelings of inadequacy, shyness	Moving to action/alternative
Low self confidence	Movement to new intentions
Difficulty accessing ideas	Music and imagery – strengthening and motivational
Dismissive of self-ability	Expressions of regret
Resisting musical participation – choosing not to	Expressions of confusion and being disempowered,
Being willing to try	demotivated

Table 3.5: Comparison of diagnostic groups – Theme 2

Major Depressive Disorder	**Schizophrenia-spectrum**
Hesitant to begin musical improvisations	Indicates preference to follow therapist's lead
Seek clarity in music making	Seek clarity in music making
Exercised choice and initiative	Exercised choice in music making
Expressed feeling stuck in music making	Resistant
Expressed being in darkness	Expressed lack of enjoyment of the drum
Not being able to move	Expressed irritation
Low self confidence	Loss of interest
Dismissive of own musical ability	Expressed feeling stuck in music making
Reflecting on symbolic material in imagery	Expressed feelings of isolation
Willing to try in musical participation	Frustration
State intention to move forward	Dismissive of musical ability
Loss of agency in decision making	Willing to try in music participation
	Expresses persistence

	Reflects using metaphor Loss of agency in decision making

3.4. Theme 3 - Grappling with the desired future

This theme deals with clients' perceptions of the future. Responses reflected in the data include suicidal ideation, self-harm, unable to face the future, doubt and skepticism, desire for independence, escaping the realities of life and envisaging the future.

3.4.1. Ending it through suicide (VR08)

Some clients in the MDD-group had either attempted or contemplated suicide prior to hospitalization. References to suicide in the data suggest that clients indicated wanting to end it all due to present and future reality being experienced as overwhelming.
"It's sadness that pushes you to the edge and want you to escape to somewhere, where you will feel at peace, or end it all", "there was a time yes, when i wish I was, yes" (A20 2o), "I don't even want to live" (R20 2i).

Client E shared in sessions 2 and 7: "I still feel guilty about committing suicide" (E22 (4d), "*I feel scared and lonely*. What do you feel scared about? *That I might relapse.* And, how might that be for you, if you were to relapse? *Difficult.* What is the fear around relapsing? *That the same thing is going to happen to me'*. In session 8, the client selected the word 'motivate' to represent how she was feeling in the present moment. The client referred to her envisaged future management of such feelings: 'In what way can you motivate yourself. *Telling me it's ok if I feel down. I shouldn't think about suicide and cutting myself.* Mm, and so what might you think about doing when you do feel down and those feelings and thoughts do come? *Write it down. Write my feelings down. Look at my promise ring, because I gave myself a promise ring.* What does the promise ring represent for you? *That I shouldn't think about suicide and about cutting myself."*

Other references include: "I was thinking about suicide just to get away from it" (F19 1v) "*miskien hou ek baie dinge in my wat ek nie uitgee nie, dit is binne, dit wil nie uitkom nie,*-perhaps I keep many things within me that I can't express, it is inside, won't come out' 'It builds up, you think other stuff, soos

daardie ideas –like those ideas" (referring to suicide) (F23 5n).

"I feel down, I feel bad, I'm feeling stressed, that's why I came hospital, it's better I kill myself, I'm useless" (J19 1f). This client had also lost a sibling due to suicide and referred to this during the conversation. The client referred to her suicide attempts in sessions 3, 4, 6 and 8: "I thought I was useless. It's better I die" (J21 3i),"I know where I come from, and I didn't have love. I was nearly dead, committing suicide, thinking it's over" (J22 4n), "I don't think now to commit suicide again" (J246k), "I tried to commit suicide two times, but still I'm here" (J26 8g)

3.4.2. Doubt and skepticism about the future (VA101) (VR14, VR41, VR47, VR127, VR173)

For some clients the future was contemplated with questions and feelings of doubt and skepticism. Examples from the data include: "I find life very difficult, but not in the sense of having to work hard and all that, but in the sense of making sense of life. I have so many unanswered questions, so many heavy questions, intense questions and how does it all fit together?" (B19 1t), "My question to myself yet again is where to from here" (G23 5a), "What is going to happen to me?" (J21 3d), "It's very hard to go there. It takes a lot, because I've been here for a long time..15 yrs is holding me back" (A20 2q, 2y), taken directly from the client's written story text: "Do we really live in such a *sinical* world that even no matter how hard you try night and day is always such a reality and in between the *realysasion* of such" (G23 5ai).

Clients expressed doubt about the possibility of an improved future or the prospect of healing and recovery:-"I don't know if I'll ever, I don't know when I will ever be to there, I tried a lot" (A20, referred to in 2t), "I don't know if it's really going to happen, but I think it has to be tried"(A20, referred to in 2ac), "is it worth the effort?..if it's not real then there's no point" (B19 1x,y), "feel I am wasting my time", "it won't help. I will keep quiet" (D20, 2o, D21 3s)," Maybe in some cases it's not possible to heal anymore", "I don't know if I'll be able to be myself again" (G19 1m, 1ae), "How do I ever recover or free myself from such fear?" (G23 5avi), "*sal nie help nie* – it won't help" (H25 7l).

3.4.3. An impasse, with unwanted dependency (VR03, VR04, VA88)

In a two-step music-centred clay process, Client A explored the theme of dependency which highlighted references to dependency and a desire for independence. In the first part of the process Client A created a small fish from clay. The fish symbolised a baby fish dependent on its mother: “small fish following mother..teaching small fish to swim…currently is small fish trying..I felt like a baby fish who can’t look after himself” (A255 4e,f,u,q). The client was invited to rework her image or create something different with the clay to represent a different, desired self. She created a larger fish about which she explained: “I would like to be the mamma fish. Um it's grown up now, the tail it's little bit bigger so it can wiggle itself, and it has this fins, it is strong, it can flick other fishes and turn when they come, with their fins”(A20). In session 7 she referred back to the metaphor of the fish and said:“The journey I am travelling is very, very difficult. I get a lot of obstacle, and every day I have to use what I've got, from the support that I get. I have to be like the Mamma fish. Start growing up and not being stuck. It's scary, it's difficult, it takes a lot of determination. I know that I'm getting there being a Mamma fish, it's quite empowering” (A25 j, k).

Other clients shared feelings related to both dependency and the desire for independence: “Feel empty, onbevoeg um unfulfilled and I want to do things I want to do or can do, *self bewus* (self-conscious), I feel angry in myself, I feel dependent, sometimes lonely and unhappy” (F25 referred to in 7e, 7v), “me, I can’t comfort myself, I need someone to comfort me” (J20 2n), “Yesterday is not like today. I must move on with my life. I live once. I come alone in the world, I go alone. I must help myself. Help and teach my grandchildren” (J26 8l).

Client T, in session 4 referred to the need for protection using the metaphor of the goldfish to represent himself: “*wat nogsteeds die goudvissie protect binne my*- that still protects the goldfish within me” (J20 2n) and in session 3 said “*Dat jy op jou eie voete kan staan. nie te veel vertrou op ander mense, sterk wees in jou lewe* – that you can stand on your own feet, don’t rely on other people too much, be strong in your own life”.

3.4.4. Escaping from the realities of life to some ideal situation (VA 138) (VR36, VR37, VR42, VR51, VR65, VR194, VR195, VR201)

"It is a place I wanna be, no stress no pain, no suffering, not waking to a day when you feel it should never be. A sense where there is love laughter, a place where everybody would like to be"… It was a sense of serenity, um it's peaceful, there's no interruption… I feel like I was watching from the distance. It was like wow, this is. I wish I can be there under the trees watching them, the fishes and the birds. They feed on the apples, and to watch the waterfal" (Image 3.5 Client A, session 1 – A19).

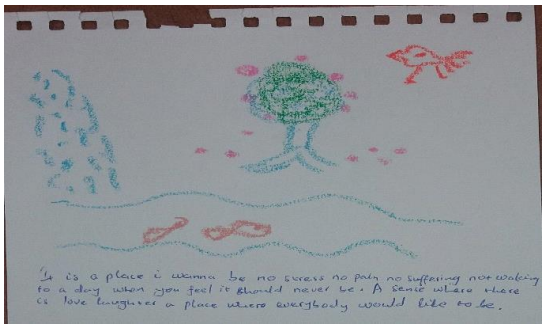

Image 3.5. (Client A - MDD, Session 1 – Escaping to the ideal)

The data indicate numerous references to a future/desired state which is idealised and contrasted from a perceived unmanageable reality. The themes of escape, safety, being rescued and grandiose ideations are amongst these references. Examples from the data include: "escape to somewhere where you feel peace" (A20 2n), "It makes me relaxing, I wouldn't mind being there now" (F19 1e), "*Ek sal graag daar wees* –I really want to be there.., *dit is meer calm, relaxing*- it is more calm, relaxing"(F20 2t), "If I must face life today it's just impossible" (G19 1n), "but the next morning when I wake up, it's the reality that kicks in again, So difficult" (G19 referred to in 1s), "Today yet again I will not face the world. For the fact I cannot even see clearly thru the pain and depression" (G23 5aii), "Go to sleep at nine and listen to some nice music. Take me to a different place, a different way of thinking. It motivates me so music that I can't understand why in the mornings I am so down. In the evening when it gets dark I feel so secure, even though I'm in hospital, it's a sense of achievement that I've actually gone through the day, which is very difficult sometimes. You feel you can move the world at that stage. The music is so incredible. Takes you to such a different space" (G22, 4c-g). Referring to music therapy sessions he said "I enjoy the music and the calmness and escaping the memories" (G15 3q), believed through supernatural powers

that he could create wealth (M25 7f).

Other references include: imagined an ideal world free of suffering and refers to heaven with no sickness or death (H24 6e, H26 8i), with reference to clay image:,"sunshine replaced dark cloud and barrier removed" (I22 4m, 4n) and in her story text "from loneliness and torment to happiness and feeling content" (I23 5c), "It's chaotic, everyone in a storm needs shelter. This is a place with no more storms. There is happiness. After the storm there will always be sunshine" (P24 6e,6f, 6g), "handed it over to God and feels safe" and regarded moving forward as bringing safety, freedom and a "normal life" (R22 4q, R24 6h00. Client S, in a story text referred to being rescued by a prince (S23 5c).
Contrasting to the notion of escaping to an idealised space, Client S indicated that she would choose the safety of the lock up ward over the adjustment to an open ward (she had been moved from the lock up ward during the week of session 6) and Client T referred to have a greater sense of safety and trust within the darkness rather than the light (T24 6g).

3.4.5. Envisaging a desired future (VA137) (VR 43, VR61, VR85)

This sub-theme is an extension of 3.4.4 in that clients articulate desires and hopes of their envisaged future. These utterances refer more directly to statements of a more concrete nature. Examples from the data include: "Yes, I can glimpse a step because I'm looking forward to um to being trained by Yesne[1] (her sister training her to run a nursery) so that I can get the skills on how to run financials and stuff like this" (A23, session 5). She referred to the symbol of the sun in one of her drawings as a symbol of hope (A24), "there's no future for me..I need a better life…to go to school or get a job" (D20 2i, D22 4f, 4l), "I want to be a pediatrician"(E24 6u), "Ag this is just how I feel. Feel empty, onbevoeg um unfulfilled and I want to do things I want to do or can do, self *bewus* (conscious), I feel angry in myself", he states that he wishes to support his mother as he feels responsible for her (F19 1x, Iy),(F25, session 7), "I wouldn't mind to get married again, and maybe have a baby" (G25 7n), envisages her family being together and offering her child what she did not have (I22 4o, I22 4i), O20 2g),"Yes I want to go to my relatives (O20 2g), "I've got life going on for me" and "love for what I'm hoping to be"(P22 4k), hopeful for "light at the end of the tunnel"(P26 8h), seeing herself as free as a bird with her family and saw an outcome even though circumstances are difficult (S21 3d, S23 5g) and the metaphor of flying to

[1] Name changed to protect identity

represent a new beginning (T25 7k).

3.4.6. Aspiring towards financial and occupational independence (VR06, VR07, VR39, VR196, VR213, VR214

Linked to sub-theme 3.4.5 in which varied aspects of a desired future were expressed, this sub- theme refers specifically to educational levels, occupational development and financial independence: "it will be another skill….work with hands" (A23 4y), being disadvantaged by low level of education (G19 1u, J21 3e,3g J25 7c), reference to a time where she was studying and her working life expressing a desire to return to work (P25 7f, 7h), referred to his previous employment (M24 6e) and his dream of financial independence: "I have a dream to buy house and car..That one is BMW. I want to buy it when I've got money. Drive my BMW and have a house" (M20 2d, M25 7e, 7g), Clients referred back to a time in their lives when they were employed:"*Ek het gewerk. City Council of Pretoria. Op de pad. Sewe years gewerk*- I worked. On the road. I worked 7 years" (N23 5i), associated clay symbol with the work he did (Q22 4d), referred to previous work experience (T25 7i).

Clients indicated a desire for financial independence or referred to the need to take financial responsibility for family members: "I would like to support my mom more. Get a job, obviously to support her" (F22 4t), does not want to depend on anyone (J21 3n), referring to financial challenges "that's why I hate December" (J21 3o), financially supports children with pension: "*ek kry pension van die siekte..*I get pension from being ill" (N23 5j).

This theme reflects the voice of clients expressing hope, despair, intentions, dreams, stark realities, plans, fears, impasse, motivation, cynicism, doubt and longing with regard to a desired future which for some feels out of reach and for others a 'light at the end of the tunnel'.

3.4.7. Comparative findings – Theme 3 (Grappling with a desired future)

Most striking in Table 3.6 is that Receptive Music Therapy techniques exclusively gave rise to this theme, eliciting feelings associated with suicide, emotional impasse, cynicism about the future, desire for independence and escaping current difficulties.

Table 3.7, which differentiates between the two diagnostic groups highlights MDD-group's numerous references to suicide, where there was only one in the SS-group. The MDD-group highlights references to emotional impasse and expressions of doubt and cynicism. Both groups articulated feelings of being stuck in their dependency of others and in contrast, also expressed the desire for personal and financial independence. Both groups articulate a desire to escape from reality, expressed as the ideal in the MDD-group and in grandiose terms in the SS-group.

Table 3.6: Comparison of music therapy techniques – Theme 3

Responses elicited by Active Music Therapy techniques	**Responses elicited by Receptive Music Therapy techniques**
	Feelings associated with suicide Questions and feelings of cynicism Emotional impasse Imagery and feelings related to dependency Imagery linked to escaping difficulty Hopes and personal desire Aspects of personal story Desire for independence

Table 3.7: Comparison of diagnostic groups – Theme 3

Major Depressive Disorder	**Schizophrenia-spectrum**
Numerous References to suicide Reference to emotional impasse Expressions of doubt and cynicism Expressing feelings of dependency Escaping to the ideal Articulate specific future hopes Reference to education level Expressed desire for financial independence	One reference to suicide One reference to feelings of dependency Grandiose reference to wealth Reference to safety within security ward Reference to safety within darkness Expressed future hope Desire to be with family Reflected desire for freedom with metaphor Reference to concrete items associated with wealth Expressed aspects of personal story

3.5. Theme 4 – Hurt and fear of undesirable unknown

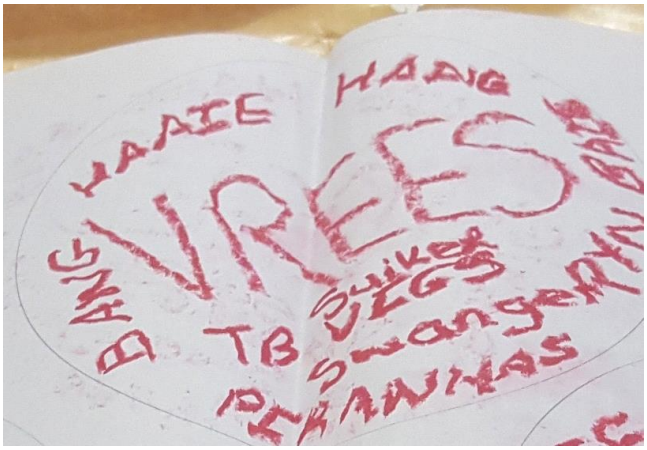

Image 3.6. (Client H (MDD) – Session 7 – Fear)

Translation *(Bang, vrees, haaie, pyn baie, swanger, vigs, TB, pirannas – scared, fear, sharks, much pain, pregnant, Aids, TB, piranna fish)*

Theme 3 expresses varied ways in which clients articulate aspirations and questions concerning the future, often perceived as threatening or ominous. These responses ranged from not being able to face the future to fantasies of escaping to an idealised emotional space or set of circumstances. . This theme expresses clients' references to trauma and hurt as well as the impact of past hurt or trauma on the future, similarly envisaged as ominous or undesirable. Image 3.6 illustrates the expression of fear, pain and trauma in the depiction of current circumstances.

3.5.1. Disabling impact of trauma (VA119) (VR09, VR10, VR158, VR200)

The first sub-theme is expressed through examples from the data which illustrate how past trauma affects lived experience in the present as well as impacting perspective for the future.
"It just hurts so much more because I was a child" (I22 4ae, 4af), "my husband beat my daughter with a hammer. My husband slit his throat".The client shared about her own health and one of her own siblings had committed suicide in a traumatic manner. "I was very stressed when I came here" (J19, 1j), referring to the murder of her mother: "It was stormy because she was murdered. She did not die a natural death. It was very traumatic"(P24 6j, 6k).

Client G (MDD) referred to traumatic incidents throughout the music therapy process and refers to the impact of the trauma on his daily functioning: Firstly, in session 7 he made reference to how he experienced his emotions prior to the traumatic incidents: “I was a lot more aware of my emotions at that stage. I could relate to how I feel. There was a stage in my life that I could freely explore my inner being, If I wanted to be sad I was sad” (G25 7e, 7f). He then refers to how the trauma impacted his life:

> *“The last one I would say sadness. Remembering the way it used to be. Then also a bit of fear and the unknown, and that's a big problem after the two hijackings and the burglary. I always used to check everything six or seven times before I got into bed. Always felt uncomfortable, won't drive certain areas because it's too dangerous, totally changed my life. I will never drive in the area. I will never go there again”’ (G21 3k, 3t).*

The disabling impact of trauma is expressed as: “it’s sort of a blank” (G4 1o), an improvisation expressing fear in which the client linked his fear to the colour black “hard to switch off” (G11 3b), associating a time of day with the trauma: “I normally miss that time of morning because of fear. If I can overcome that, one day it might be a lot better” (G22 4h), connects a physical ailment with a traumatic incident: “Even this morning when my hernia was so sore, then I would say to myself, it's because of that” (G23 5j) and he refers to 360 degrees of trauma:

> *“360 degrees of trauma. A lot of pain regarding that, that I carry around on a daily basis. It is disabling me. My trust levels are very low in people, which never was the case. There are uncontrolled emotions. It's now become a habit at night - I can't fall asleep without wandering into another world, forgetting where I am now. I see that as the only way of being capable to start healing. To actually have a fresh start and get away from everything. The fear, when I do go out, I have this fear of being hurt again, but then there's also the reality, that you can't have this cocoon around you, we live in a very violent society. I would not be able to handle it again” (G25 session 7).*

3.5.2. Ominous anticipation of the unknown (VA142) (VR31, VR70, VR215)

The data indicate that clients experience life and anticipate future outcomes as being unpredictable and unstable. The data, furthermore, suggest that clients adopt caution regarding future endeavors or ideals due to the perception of the ominous nature of the ever changing nature of lived experience.

Life as “the journey of ups and downs” (A24 6ab). She stated being “Not stable- I visit stability" "Not

stable at all' (A20 2i), "I don't really know what's going to happen there, because it can change anytime" (A20 2r). She referred to the need to be careful: "being careful that you don't get into too much excited, yes cause anything can happen, so you must not overdo it…if I can go from this place of being very much careful, or this person will hurt me, or my sister will turn back or whatever, to these areas of life where other people enjoy" (A21 3i, m, o; A21 3au), referring to the image of the fish cited earlier: "Yes. It's following the mother, the mother is teaching it how to swim, and how to be careful" (A21 4f).

Client F, indicating a desire to be involved in performing music yet skeptical of a good outcome says: *"Yes it sounds dat ek dit sal kan doen, maar dit sal nie oornag gebeur nie* – Yes it sounds as if I can do it, but it won't happen overnight" (F20 2w).

Further references include: "It relates to the fact that while I'm still waiting for the unknown I can have my peace … I don't know what will happen. I cannot control it, I cannot change it. I have to wait and see. It develops emotions of uncertainty because you don't know what is coming" (P21 3e, 3i)"It's Life. You can't predict it. You don't know whether this kind of storm will come. You don't' know if you will stay there forever" (P11 6a).

In referring to his future through the metaphor of a bird taking flight for the first time said: "*Bang, dis 'n uitdaging, en ek moet dit doen. Die ander mense het dit ook gedoen. Ek weet nie of ek dit gaan reg kry want ek het nog nie gevlieg nie* – Scared, it's a challenge, but I must do it. Other people have also done it. I don't know if I will get it right because I have not yet flown" (T25 7m).

3.5.3. Fear of hurt and the unknown (VA11) (VR33)

The data indicate numerous references to fear. These references relate to current experiences of fear as well as projected fear of future hurt and disappointment.

References include the fear of venturing out, the fear of losing her mother, the fear of being hurt. In addition she articulated the fear of the strengthening process, acknowledged the need to stop being scared but acknowledged "I'm a little bit scared". With regard to moving forward and future decisions: "Start growing up and not being stuck. It's scary, it's difficult, it takes a lot of determination"(A21 3h,3ab,3am,3ap,3av, A23 5ai, A25 7l).

Other references include: Coming out of the cocoon, regarded as her safe space said: “I feel scared and lonely” (E25 7i), referred to the fear of being laughed at (F23 5s), linking this to his mistrust in others in terms of sharing feelings more openly (F23 5r), fear of the unknown, wanting to get rid of the fear he experiences due to previous traumatic incidents, “normally miss that time of morning because of fear”,fears getting hurt again, in preparation for an improvisation on confronting fear, described his fear as “pitch dark”, “I’ll say it’s so overwhelming that’s it’s with me constantly in the day” (G21 3e, 3i, 3q, G224k, G25 7p, G11 5a, 5e).

A pronounced tremor is ascribed to fear: “*Ek glo nie dis medikasie nie. Ek het 'n vrees. …Yes, baie angst* – I don’t believe it is the medication. I have a fear..yes, a lot of anxiety”(H6 2u), “*Bang, maar ek het krag gekry van die Here* – scared but I got strength from God”, “*ek voel leeg, bang* – I feel empty, scared” (H23 5h, H24 6f), afraid to feel emotion, afraid to speak emotions, “the fear, the thing of fear, the loneliness”,and said with regard to a future decision:“yesterday I made the decision that I am going to go back to work, I'm also a bit scared” (I19 1h, I11 3e, I11 5f, I12 6i), described self as very afraid (S20 2c) and indicated being afraid to venture out, as quoted in 4.2 “*Scared*, it’s a challenge, but I must do it. Other people have also done it. I don’t know if I will get it right because I have not yet flown” (T25 7m).

3.5.4. **Comparative findings – Theme 4** (Hurt and fear of undesirable unknown)

When comparing how the music therapy techniques respectively gave rise to this theme, Receptive Music Therapy elicited feelings, memories clients’ and symbolic material associated with trauma, fear and unpredictability, and clinical improvisation was appropriated by clients for the musical expression and reflection of what was elicited through Receptive Music Therapy techniques.
With reference to the differentiation of the two diagnostic groups, both groups articulated similar verbal responses through reference to past traumatic incidents and the unknown, articulating feelings of fear and uncertainty and using metaphoric language to express these sentiments.

Table 3.8: Comparison of music therapy techniques – Theme 4

Responses elicited by Active Music Therapy techniques	**Responses elicited by Receptive Music Therapy techniques**
Improvisation linked to the symbolic Mind being blank due to trauma Reflected on theme improvisation by referring to impact of trauma	Memories of traumatic events Feelings associated with trauma Feelings related to life's unpredictability Expressed feelings of fear Symbolic material to express fear and trauma

Table 3.9: Comparison of diagnostic groups – Theme 4

Major Depressive Disorder	**Schizophrenia-spectrum**
Related traumatic incident Articulated feelings of fear Articulated feelings of uncertainty Referred to impact of trauma Expressed fear of the unknown Use of metaphor to express fear of venturing into unknown	Recalled traumatic incident Articulated feelings of uncertainty Referred to the unknown Expressed fear of the unknown Use of metaphor to express fear of venturing into unknown

3.6. Theme 5 - Sadness, brokenness and futility

This theme is voiced through the sub-themes: i) telling about sadness, ii) brokenness, iii) hardship and struggle and iv) feelings of futility.

3.6.1. Telling about sadness (VA04) (VR01, VR02, VR11, VR22, VR81)

Clients articulated feelings of sadness, low mood, depression, unhappiness and disappointment, as illustrated in the images below (Image 3.7). For some clients these feeling were pervasive in terms of daily living, whilst for others sadness was mentioned with reference to a particular incident or relationship. Whilst more references relate to the MDD diagnostic group, there are numerous references to sadness by clients in the SS diagnostic group.

Image 3.7. (Top images-Client L, Bottom image - Client F - Sadness)

Examples from the data include: - feeling sad (A20 2f), sadness pushes you to the edge (A20 2m), "I am not very happy", she further described herself as very depressed, disappointed as expectations were not met and talked of having worked in an unhappy working environment; "well I'm not happy at home" (F19 1h) and "I feel dependent, sometimes lonely and unhappy" (F25 7w), "Sadness, ag it's just you live with these anxieties, you don't realise nature anymore…So much lost time", "cause if you so depressed that you don't want to let people see how you actually are, because you are putting up a front for people", (G19 1d), "I'm down all the time" (G25 7bv), references to being heart sore (H20 2i, 2j, 2n; H25 7j, H28 8h), referring to depression as "a barrier line", "I can move closer but the barrier's still there" (I22 4h), "my heart was very sore, very red inside, I know I'm heartbroken" (J24 6e), "feeling down, stressed, down,there was sadness and crying" prior to being admitted to hospital (J19 1e, J20 2g, J8 5k), "heart of tears, heartbroken, sadness stays with her, someone whose heart is broken" (L19 1c, L20 2ev, 2x, L21 3e) and questions: "am I not supposed to be happy?" (L19 1i), feeling heart sore and said "*my hard is sear* – my heart is sore" and (O24 6f, O24 6c). In an earlier session she drew the image of a tree which represented growth and strength. In session 7 she drew a leaf and said: "The small leaf is like the

people unhappy" (O25 7i), a memory elicited by the music of her mother's funeral and the music calming the sadness (P19 1f), "Sad me, makes me think of my life deeply" (P20 2civ), heart sore "*net hartseer"* as the music elicited memories of a previous relationship; referring to being in hospital "I'm getting depressed in the whole story. I'm not feeling good today" (R20 2l).

3.6.2. Brokenness (VR16, VR24, VR157)

This sub-theme, linked inextricably to the sub - theme of sadness, deals with references to feelings of pain and brokenness at both a personal and relational level. Referring to feelings as "sadness and hazardous" (A20 2l), "in my case the journey that I'm on it's painful, but I have to travel it" (A23 5i), "something broke me – from there it went down" (B19 1i), "I feel like everyone is smashing me" (E22 4h), "A lot of pain regarding that, that I carry around on a daily basis" (G27 7bi)' "*erg, gebrokte liefde,*- serious, broken love" (H24 6g and Client L also referred to heartbreak and betrayal referring to a broken relationship, "my heart is broken", referring also to being heartbroken if wrongly accused (L20 2g,2h, L19 1k, L20 2i), referring to her attempted suicides said; "Forget about the past, which was very sore to my heart. They were hurting and I keep them in my heart" (J26 8h, 8i).

3.6.3. Hardship and struggle (VR48, VR58, VR94, VR167, VR174, VR176)

Imagery elicited by the music offered symbolic ways for clients to talk about their stories and experiences. The data indicate a number of symbols which were used by clients to share aspects of struggle and difficulty:- Client I (MDD) drew a whirlwind (Image 3.1) to represent unmanageable and inexpressible emotions, created a barrier and dark cloud from clay to represent depression (Image 4.1), used the image of a lonely fairy travelling under a dark cloud in a story text and drew a prison cell and tears (Image 3.8) to represent being a prisoner to her emotions (I21 3b, I25 7i).

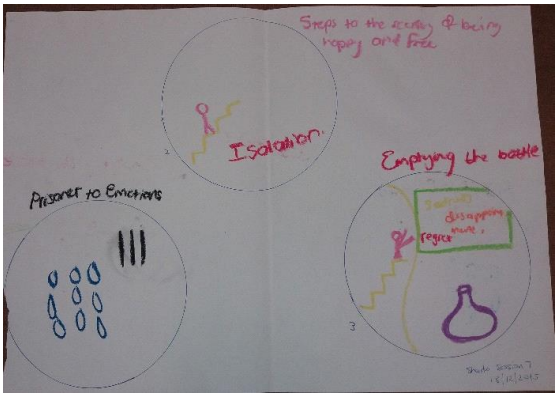

Image 3.8. (Client I - MDD, Session 7 – Prisoner to emotions)

Other images included: The use of the colour black in an image referring to heavy, anxiety and moody (A20 2g), the title of a story text "The worst journey to be endured" (A23 5c), an image of a stunted figure in red – text at the top "I hate my Dad" and an incomplete sentence.. "because he di…". The image was torn up later in the session (D, session 1), a black cloud representing grief over the loss of relatives (J25 7e), the image of a storm included in a story text which represented the challenges in her life story (H23 5dii), a heart pierced with an assegai to represent broken love (N24 6e), an image of personal items of clothing representing feelings of sadness and loss of personal identity (O25 7b), a ball created from clay to represent the self being played with "because people play with me like I'm a ball . In my situation - they're nice to the ball, it's this way, that way , now you go home, now you don't go home…..It's a game, with only one player, I'm not allowed" (R20 4b), an image out of clay of a disabled man representing the challenge of confinement (S22 4c), the fantasy image of Thumbelina in a story text representing the need for rescue (S23 5a), metaphoric references to a whale/shark to represent parts of self which could be destructive (T22 4f).

The symbols enabled clients to access and talk about difficult emotions and aspects of their experiences related to hardship and struggle. Data references include: - "the journey is very, very difficult", "I get a lot of obstacles", "long term struggle", "a long time of living with this", "15 years is holding me back" (A 25 7g, 7h, A23 5c, A20 2r, A 20 2x, 2y), "I'm confused because this is very difficult", "I find life hard – in making sense of it" (B19 1l, 1w), "so difficult", "all the crap trials around you", "felt like this forever" (G23 5i, G24 6d, B19 1h), indicates that the storm reflects something of her life and in the following session disclosed difficult, very personal information which elicited distress (H23 5f, H24 6h), referring to a black image, "This one, things are very bad, they are black , then I cry", "I feel emotional, I feel down, I

feel scared, I feel rejected" (J20 2d, 2g).

3.6.4. Feelings of futility

This sub- theme is expressed through feelings about self and circumstances which reflect hopelessness, helplessness, despondency and futility. Examples from the data include: - seeing self as weak, "I'm just too weak, too soft" (G19 1v, G21 3l), reference to unfulfilled life goals (A21 3ai), "Feel empty, *onbevoeg* – unfulfilled" (F25 7t), "feel hopeless, on my knees, can't stand up" (A20 2p), "the third year when I was diagnosed, it's like everything is over"'(A21 3ag), "I'm so angry and helpless" (A24 6o), "*ek voel asof ek daar inval, niemand help my* – I feel as if I'm falling in, no-one helps me"(H26 8e), "can't change anything" (S22 4j), "I cannot control it" (P21 3j), refers to depression as her opponent (A26 8g), "I've tried too many times" (G23 5g), "I thought I was useless", "I'm useless" (J21 3h; J19 1g), "I feel like I am useless", "I am a loser" (D20 2h, D21 3u).

This theme has highlighted clients' experiences and feelings concerning areas of struggle. These sentiments are linked to other themes which have highlighted, e.g., anticipation of ominous future, not being able to face the future, finding difficulty expressing and accessing feelings or finding the motivation to proactively initiate change.

3.6.5. Comparative findings – Theme 5 (Sadness, brokenness and futility)

It is noteworthy, as was the case with Theme 3, that it is Receptive Music Therapy techniques which gave rise to this theme. Feelings of sadness, helplessness and hopelessness were elicited, references to brokenness, heartbreak and betrayal were made, and symbolic material was linked to unmanageable emotions.

In the case of the comparison of the two diagnostic groups, references to feeling states such as sadness, helplessness and being heartbroken were prominent from the MDD-group, whereas the SS-group referred less to feelings and more to own life circumstances, with specific reference to not being in control of circumstances. In the case of both diagnostic groups reference was also made to symbolic metaphoric material.

Table 3.10: Comparison of music therapy techniques – Theme 5

Responses elcitied by Active Music Therapy techniques	**Responses elicited by Receptive Music Therapy techniques**
	Feelings of sadness Imagery linked to sadness References to being broken Reference to heartbreak and betrayal Symbolic material linked to hardship Imagery linked to unmanageable emotions Offered access to and articulation of difficult emotions Feelings of helplessness and hopelessness Memory of life event

Table 3.11: Comparison of diagnostic groups – Theme 5

Major Depressive Disorder	**Schizophrenia-spectrum**
Articulated feels of sadness Linked symbolic material to sadness, difficulties and unmanageable emotions Articulated feelings of being heartbroken Expressed pain Stated intention to leave past behind Articulated feelings of helplessness Articulated feeling of being useless	Linked feeling state with symbol Related life event linked to sadness Reflection on own life Reference to archetypal/universal symbol Reference to known fairytale Used metaphor to link directly to own experience Expressed not being able to change or control circumstances

3.7. Theme 6 - Anger, trust and vulnerability

Theme 6 refers to clients' expressions of anger towards self and others, feelings of vulnerability and statements about difficulties with trust.

3.7.1. Intimate vulnerability

Salient references to vulnerability refer to two clients in the study, i.e.: Client A said "To tell you the truth I'm so scared of being hurt, the stage I am I'm vulnerable" (A21 3an) and in referring to the fact that she had glimpsed a possibility for her future and an inner resourcefulness within herself, she used the metaphor of a new born chick to emphasise her caution and vulnerability:

> *"It's like the other part of me was inside, it was not yet..I never realised it. It was there, what do you call it, unconsciously. So it's like it's been revealed , I told her that I'm a little bit scared, I'm like a chicken coming out of the egg, but I'm seeing the light. Mm, Yes and although nervous but I can see" (A23, session 5).*

Client T presents as a softly spoken, anxious, and, at times, fragile man. This is in contrast to aspects of his story which indicates a history of violence and sexual offending. Client T presented with disorganised thought and speech in most music therapy sessions.

Image 3 referred to earlier in the chapter was part of a 2 step music-centred clay creation process. Client T created a Goldfish, (see 3.4) about which he said:

> "*Ek is 'n Pisces , ek dink ek's soos 'n goudvissie. Ek kan maklik seer kry, voel amper vir my, ek weet ek's nie die belangrikste in die wereld nie, maar soos met die musiek ek kon 'n haai gemaak het of so iets, ek is so gevaarlik soos 'n haai, en ook so sag soos 'n goudvissie,…, 'n mens moet baie versigtig wees hoe jy 'n Pisces hanteer, want hy kan baie gevaarlik wees, baie sag wees, hy kan baie hard wees, delikaat*. - I am a Pisces, I think I'm like a goldfish. I can easily get hurt, feels almost like, I know I'm not the most important in the world, but with the music I could have made a shark – I am as dangerous as a shark, but also as soft as a goldfish, people must be careful how they handle a Pisces because he can be very dangerous, very soft, very hard, very delicate" (T22 4g).

For step 2 the client was invited to rework his original clay sculpture or create something different with a new piece of clay, if he wanted to change/add anything to what was created during step 1. He asked for a new piece of clay and created a red heart with green wings as illustrated in Image 3.9:

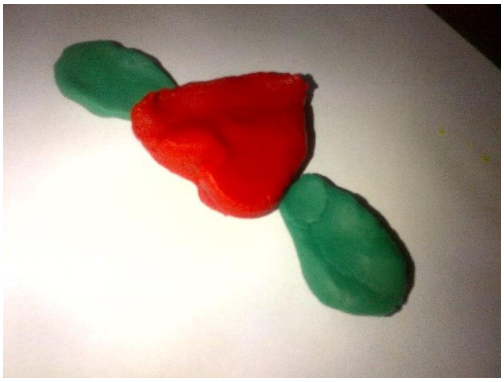

Image 3.9. (Client T - SS, Session - Step 2 clay process)

When asked to reflect on the second clay sculpture the client said:

> *"soos 'n engel, jou hartjie vlieg, ek's naby die natuur, my hart is net van bloed gemaak, ek is 'n normale mense, die goudvissie moet in my hart bly, nie die killer whale. Ek kan die killer whale wees wat nogsteeds die goudvissie protect binne my. Enige sagte vrou soos my ma* - like an angel, your heart flies, I am close to nature, my heart is just made of blood. I am a normal person. The goldfish must stay in my heart, not the killer whale. I can still be the killer whale that protects the goldfish within me. Any soft woman like my mother"

Through these clay images the client reflected on a) his destructive self – the capacity to inflict harm by referring firstly to a shark and then later, a killer whale, b) his vulnerable, sensitive, soft, easily hurt self - referring also to himself as not being the most important, and just being a normal person, c) reframing the role of the killer whale also as protector, d) the final statement referring to his mother is linked to i) need for protection, ii) the relationship with his own mother and iii) projection onto the therapist who was often likened to the client's mother throughout the process.

Seen in the broader context of the 8 music therapy sessions, in both step 1 and 2 of the clay process during session 4, Client T makes reference to a vulnerable self, almost as if this part of himself needs protection from himself. Whilst this session could be interpreted in multiple ways, which is beyond the scope of this chapter, Client T refers to his qualities of sensitivity and vulnerability as desired above the destructive parts of self. The child-like, fragile quality with which he engaged in the clay process is best described by the title of this sub theme, intimate vulnerability.

3.7.2. Anger at others and self (VA47, VA50) (VR53, VR145, VR171, VR204)

The next sub-theme, anger, is represented through the voices of different clients, the majority from MDD-group and one client in the SS-group. Anger is expressed with reference to angry feelings towards self but also anger aimed or expressed at others.

Client A refers to the red figure in Image 3.10 as herself being angry: "I'm feeling very angry, I'm still angry' (A24 6i, 6r, 6u) and in session seven said 'I'm still having that anger" (A25 7v).

Image 3.10. (Client A - MDD, Session 6 - Anger)

Client D wrote: "I hate my dad, because he did…".She became emotional as she wrote this and could not complete the sentence.

"I asked whether she would find it helpful to complete the sentence – she declined. She started talking very softly as if to her father. I then suggested she could do what she wanted to do with the paper and I played a piece of music again. Eventually she began to tear up the piece of paper (Image 3.11), all the while sobbing" (Post-session field notes, Client D session 1). The session was concluded with drumming. Afterwards she commented that it "release some anger" (D19 1k).

Image 3.11. (Client D - MDD, Session 1 – Anger)

Client E, referring to an abusive relationship said “I just feel angry and aggressive”, “would like to break something” (E19 1h, 1j), referring to an image she drew in session 2 she referred to the red as representing anger and said “what makes me angry is when my stepfather shouts at me” (E20 2i). Client F (MDD) referring to being unhappy in his home environment said “Yes, I think my main issue now is my sister's son at home. The anger” (F19 1aj), “I feel angry in myself” (F25 7u), “alone, angry, isolated, disconnected, anxious, tense and that is why I'm frustrated” (F26 8f) and as a means of addressing his anger he stated “Yes I think when I feel anger, then I can write down, and maybe that will” (F12 6m).

Client G expressed anger to self and others: “it's just making me hate myself” (G19 1x), I was never a hateful person, but these days I do carry a bit of hate around” (G25 7s)

Client H disclosed during session 6 that she had been involved in an aggressive incident on the ward: ”*Ek sou more uitgekom het, toe het ek, daardie glase wat teen die muur is, ek het hom gerbreek. Ek was kwaad gewees* – I would have come out tomorrow, then I broke the glass against the wall. I was cross” (H24 6k, 6l). She also referred to having hurt her husband (H22 4g, H22 4n). Referring to an image consisting of shapes and colours, Client I said “This is anger, this is like hurt anger (shook as she said that), this is almost like anxiety and anger, combined” (I20 2g) and Client J referred to “getting angry easily” (J23 5k).

Client T (SS) referred to a symbolic struggle between the themes of darkness and light which were

elicited through a music listening technique. These themes were played out in an improvisation during which the client said that he was experiencing the fight within him (T11 6g).

3.7.3. Difficulty in trusting others (VA77) (VR45, VR46, VR141)

This theme is expressed through statements clients made about difficulties they experience with regard to trusting others: "it's hard, let go of not trusting, trusting that the person cannot mislead you, and desire to trust sister" (A21 3ax, A14 2h, A21 3ay)' "don't trust people that much" (E23 5n), "what makes me jealous is because my mom trusts my brother more than she trusts me" (E20 2h), "don't trust anyone" (F23 5r), "My trust levels are very low in people" G25 7k), "*vertoue ek sukkel om mense te vertrou* – trust , I struggle to trust people" (T23 5j), does not easily trust (T21 3h, T25 7f), "I think I should put my trust in, even if it's one person at a time" (I25 7ai).
Whilst the examples cited above refer to clients' direct statements about difficulties trusting, there were also inferences to trust difficulties with regard to the medical system in terms of diagnoses, medication, recovery and hospitalization (Clients P, R, F, G), towards significant others as well as the process of recovery or the prospect of future opportunities (Clients D and E), and a general distrust in the future and the possibility of recovery (Client B).

Trust difficulties seems closely linked to other aspects presented in these findings, such as anticipation of an ominous unknown, hurt and fear of the unknown, feelings of futility and doubt and skepticism about the future.

3.7.4. Comparative findings – Theme 6 (Anger, trust and vulnerability)

When comparing the respective music therapy techniques, Receptive Music Therapy elicited a range of feelings including anger, vulnerability, self-hate and aggression. Traumatic memories and awareness regarding trust difficulties were also elicited through Receptive Music Therapy. Active Music Therapy was appropriated to reflect internal conflict through improvisation and awareness of trust was elicited through mirror image movement.

When differentiating between the two diagnostic groups, both groups articulated difficulties with trust. In the case of both groups it was through engagement with and reflection on symbolic material that this

theme, anger, trust and vulnerability, was expressed. Amongst the MDD-group specific reference was made to music accessing the unconscious, as well as to named feelings states.

Table 3.12: Comparison of music therapy techniques – Theme 6

Responses elicited by Active Music Therapy techniques	**Responses elicited by Receptive Music Therapy techniques**
Improvisation used to reflect internal conflict Mirror image raised awareness of trust	Symbolic material linked to feelings of vulnerability Reflection and shifting perspective Feelings of anger Feelings of aggression Feelings of self- hate Awareness of difficulties with trusting Traumatic memory

Table 3.13: Comparison of diagnostic groups – Theme 6

Major Depressive Disorder	**Schizophrenia-spectrum**
Articulated feeling vulnerable Reference to music revealing unconscious material Articulated feelings of anger Could not verbalise traumatic incident Expressed feelings of self –anger and hate Articulated difficulty trusting Referred to symbolic material to articulate feelings	Expressed vulnerability through reflection on symbolic material Reflected on different aspects of self Linked one image to another Linked metaphor to internal conflict Articulated difficulty trusting

3.8. Theme 7- Desire for connection and affection of others

A prominent theme salient to all clients across both diagnostic groups were references to being alone, lonely, isolated, missing family, loss of relationship and the need for social connection, support and love. This theme is expressed through four sub-themes: a) Loneliness and isolation, b) Loss of others, need for social connection and d) desire for intimacy/love.

3.8.1. Loneliness and isolation (VA 53, VA125) (VR13, VR 63, VR64, VR82, VR83, VR97, VR98, VR160, VR197)

Numerous references illustrate the feelings of isolation and loneliness expressed by clients. These included utterances about being alone, away from and missing family, lonely, rejection, isolated and wanting to go home.

Feels alone (A21 3ac), "I'm far from home, so I'm caught between here and here" (A24 6q). She also referred to the fact that she tends to "push others away" (A25 7u), "he telephones seldom", "I don't ever see him" (C19 1h, 1j),"I feel like I'm alone now", "no one is there for me","'I can't, cause I'm all alone" (D20 2j, D22 4c, 4j)' "I like being alone", "I feel like I'm in a cocoon", "I don't like people" (E20 2l, 2m, E22 4g, 4i, E25 7t), "I don't have friends", "don't want to feel lonely anymore", "I want to go home", "I feel scared and lonely", "loneliness made me feel guilty". She reflected on the loneliness she experienced before admission to hospital (E24 6r, E2 3i, E11 3g, E25 7i, E24 6i, E24 6h). Feelings of being lonely and unhappy, alone and disconnected (F25 7e, 7w, F26 8f)' feels alone, avoids social situations, expressed the loss of family and a longing to go back to his previous life pre the trauma (G26 8avii, G19 1f, G20 2f, 2i), missing her parents and her husband: "*ek wil by my man wees, want ek is baie life vir hom* – I want to be with my husband because I love him very much" (H20 2p)' "I am alone", she said "I don't let people in easily" and quoted the song from the film 'Frozen' referring to herself as the "isolation queen" and that she needs "to learn to communicate feelings". She too made reference to being away from family (II22 4d, I25 7n, I22 4j, I25 7ag, I25 7m, I22 4e), isolated herself for long periods, and did not have anyone to assist her: "I don't think now to commit suicide again. I must also think about the good things. It was heavy for me and I didn't know who to tell. At last I found the help here" (J24 6o).

"Like someone is somewhere lonely'"(L21 3d), she referred to being away from friends and longing for a previous romantic partner. She also referred to feeling neglected (L20 2o, L20 2l, L19 1f), "I am alone with my problems" (M26 8e), missing his family, and also referred to being alone on the ward stating that he did not want to stay with other patients: "*maar ek wil alleen bly* – but I want to be alone" (N 21 3i, N224f, 4h, N26 8g), "I want to stay in Pietersburg" stating that her "stress will be finished" if she goes home to Pietersburg (O26 8d, 8g), "*dat ek 'n alleen loper was in my lewe* – that I was a loner in my life" (Q23 5f). He also referred to missing his brother (Q25 7s), "I need to go back home to my peace", "I just need to go home because this joke is going too far" (R21 3l, R20 2g) (R2 7a), "it hurts to be alone" "*ek*

voel anders, ek voel uit, asook aleen – I feel different, I feel out, also alone", "*ek voel net alleen* – I just feel alone". She referred to hurting when not with her family and that she misses her family (S21 3p, S25 7h, S26 8e, S21 3e, 3o), "*Ek is eensam, het nie vertroue en ek is emosioneel en ek sukkel om my gevoelens uit te druk* – I am alone, I don't have trust, I am emotional and struggle to express my feelings" (T25 7g).

These references from the data illustrate the extent to which almost all the clients expressed the sentiment of loneliness and being isolated from family members and friends. This is linked to the following sub-theme, loss of self and others.

3.8.2. Loss of self and others

This sub-theme is expressed through references to loss of aspects of life, relationships and feelings of grief connected to being away from, longing for or missing family, friends or romantic partners.
"This one remind me of my mom. She used to share everything, she was there for me. Um, she was supporting me a lot, eish" (D20 2x), referring to being away from her child: "cry non- stop in grief, don't get over it", "I grieve because of my child and sometimes people will say you can't go because you are sick. Then you start grieving non-stop"(L21 3i, 3j), loss of their previous life (G20 2e, H257p), the loss of childhood, "I had to grow up", "lost a lot of years" (I25 7ab, ac, ad), the loss of not knowing her father and the impact of losing her aunt and uncle: "It was very bad, growing up without my father. I didn't know him. I was not educated. Then after my uncle and aunt passed away, I see it was like a black cloud" (J25 7k). She also referred to the loss of her husband: "What's past is past. I can't bring them back. With my husband the past is past" (J25 7o), referring to her grandfather said "but now he's gone" (O23 5f), she lost a romantic relationship due to her illness: "*The man has gone*. Did you have a man? *Yes*. What was his name? *A... Ek was siek . Ek se jy kan loop, ek is baie siek nou.*- I was sick. I said he could leave. *En het hy geloop?* And did he leave? *Yes*" (O23 5f), reference to loss of his job, having to resign due to illness (Q22 4e).

3.8.3. Need for social connection (VA87, VA145) (VR59, VR66, VR142, VA143, VR146)

The previous two sub-themes illustrate the lived experience of isolation, loneliness and loss of social interaction. Clients also, though, expressed the need for social connection and belonging. This section is

presented with reference to social support, the need for social interaction, affection for and responsibility towards family members, caring for others and healthy relationships.

3.8.3.1. Social support

"This became my family because my family was not supportive, this is where I got the support" (A25 7w), "it's like a support system that I need now because I can't do without it" (A23 5x), "my family, I come from a big one and I am very grateful for those, even if its two or three out of that at least understand what I am going through. Yes, at least, because it used to be difficult, and I didn't have support at all, and I turned my back on all of them and didn't speak to them, because nobody understood Ok, and has that changed a little bit, Yes, my sister ..I'm so grateful that I still have a mum" (A21 3r-3x).

Other references include: "I need someone to help me" (D22 4o), identified one family member as a supportive figure (E21 3s), said that she felt good when supported but that she experienced care from others as difficult (E21 3t, E25 7q), "I need someone to share my feelings, because it builds up", "I need the support wherever" (F26 8n, 8o) and expressed the need for "somebody who cares about me" (F11 6a), acknowledged the need for support (G26 8r) and that she has to co-operate when help is offered (H25 7m), referring to no social support prior to admission, stated that she can't comfort herself but "I need someone to comfort me" (J26 8j, J20 2n).

Client L (SS) stated the need "to have good people around me" (L20 2s),"one friend that cares" (Q23 5i), feels as if no-one cares or wants her, and then referring metaphorically to the clay image of a disabled man said "*niemand hom wil he nie* –no-one wants him". She indicated missing her friends on the security ward when she moved to an open ward and articulated the need for family and friends in the final session (S21 3q, S22 4h, S25 7g and S26 8g).

3.8.3.2. Caring for others

Some clients referred to the need not only to receive care and support from others, but also to offer care to those around them: "it feels good when caring about others" (E20 2p), "I care for people first, and put myself second" (E25 7p) whilst stating that she needs to think about how to assure others not to

worry about her" (E26 8p), "*Ek kan goed luister, mense vertel my hul stories* – I can listen well, people tell me their stories" and "*ek kan verstaan want miskien was ek daar.* – I can understand because perhaps I've been there" (F23 5j, 5k), expressed a desire to care for the elderly and children in her community (J22 4k), stated that he should be there for others (T21 3j).

3.8.3.3. Social interaction

Some clients made reference to the need for social interaction or referred to times where social interaction was enjoyed.

"Becoming more comfortable with people", identifying the need for "more social interaction", "to be around people" and "to make friends again" (E20 2n, E23 5p, E24 6g, 6s, E25 7ad), reference to his friends on the ward (N26 8f), described self as "sociable" and recalled how she used to dance with friends, stated that she had befriended patients on the new ward (S20 2c, S26 8j and S12 1c), "*Vriende kring, nuwe vriende, vertrou ek sukkel om mense te vertrou* – Friendship circle, new friends, trust – I struggle to trust people" (T23 5i) and referred to sharing the gift of himself with others (T23 5h).

3.8.3.4. Connection with family

Many clients made reference to their families, either in terms of missing home, being away from family, as well as time spent or need for connection with family in varied ways. Examples from the data include:

Gratitude for support of family members and for her mother in particular (A2 13r, A21 3aa), "within me I need my family" (A25 7m), stated the need to be more humble with her family (A25 7m), reflected on enjoying spending time with her mother and grandmother (E19 1o), feeling better having spoken to her stepfather on the phone (with whom she had a problematic relationship) (E21 3l), she stated experiencing her mother as supportive, caring and trustworthy (E24 6p, E25 7r).
Client F referred to being unhappy in his home environment, he also reflected on having a close relationship with some members of his family, particularly his sister and mother and expressed the desire to support his mother (F19 1i, 1q).

Referring to her husband said "*ons is baie life vir mekaar* – we love each other very much" (H22 4p). Client I referred to her daughter often throughout the process describing her as beautiful and stating "I'm becoming happy. Ja, I'm seeing her tomorrow" (I19 1g, 120 2f). She envisaged and expressed a desire for her family to be together again, closer if the barrier line of her depression was not there, and wanting to give her daughter what she did not have as a child, stating the desire to foster healthy relationships with her family (I22 4i, I22 4o, I23 5s, I22 4ai, I26 8d).

Other references include: "I still want to make peace with my younger sister, but I don't know how" (J21 3l), indicated that she is in a happier space when she sees her child. When asked what she would say to her child she said "I would say be calm. God is with you, he is watching over you. Be calm. If you have love in your heart you will survive. Without love you are just this" (L19 1l, 1n, 1m). She also referred to thinking about her father saying that he was a gentle man (L20 2m, 2n), referring to the image of a heart associated that with her mother's affection (S21 3r), referred to his grandfather's farm and spoke of his siblings: "Sisters is 4, brothers is 4" and said that both parents had passed away (M22 4g). He referred to his brother who was taking care of his personal items and referred to an uncle who had been ill with diabetes (M24 6g, M26 8d), "My brothers and sisters….Ja, they come here. I miss them. They come long time, since last year" (N21 3h), he believes his family is protecting him and the community from harm by hospitalizing him: "I'm alright since 2007. They scared the community's going to kill me. They keeping me away from them" (N21 3j). He discussed a visit he received from his brother of which he said "*Hy se die familie is bly as ek hier is want ek is siek* – he said the family is glad if I am here because I am sick' (N25 7g).

Audio clip A (Track 21 – Song expressing love for children)

In session 4 Client N referred to his children: "Yes I miss them. One boy one girl. *Ek is lief vir hulle, my kinders. Ek support hulle met my pension. Last jaar het ek hulle gesien* – I love them, my children. I support them with my pension. Last year I saw them" (N22 4j). To conclude the session it was suggested that client and therapist improvise a song through which the client could express what he would like to say to his children. The verbal exchange takes place in Afrikaans. The audio clip begins with the therapist having asked what he would like to say to his children to which he replies "*ek is lief vir julle* – I love you". He is then invited to improvise a song expressing that sentiment. He continues singing their names and singing that he loves them.

3.8.4. Desire for intimacy and love (VA13) (VR 23, VR25)

The final sub-theme of this section is expressed through references for the desire of romantic, intimate and spiritual love. References include statements regarding the desire for intimate relationship and linking imagery elicited by the music to themes of love, romance and comfort.

Examples from the data include: feels robbed due to diagnosis reducing the possibility of a romantic relationship (A21 3af), desire for romantic partner (A21 3ad, O25 7g, Q23 5h,Q25 7q, G21 3p), "I have this longing to be loved again" (G257t) and other references stating a desire for romantic love (J20 2k, F25 7f, 7r, H12 6l, H18 8c, 8g, J25 7i, L19 1e, L20 2eiv), need for comfort: "I need someone to comfort me, telling me they love me" (J20 2k), love linked with survival: "if you have love in your heart you will survive" (L19 1o), associating imagery with romantic love: "just relaxing with a nice cocktail. A nice lady on the side", a memory about a previous boyfriend (F19 1g, S25 7b), references to desire for marriage and children (G25 7u, J26 8f, Q25 7i).

Other references to love included: music eliciting feelings of freedom, peace and love through imagery of nature linked to her farm, feelings of restfulness and love (R19 1d, R23 5f), "*liefde gevoel* – felt love" (T20 2i), reference to an image of a flower symbolizing "love and strength from God" (S19 1e).

The essence of this theme is expressed through the utterances of aloneness and isolation on the one hand and the need for social support, connection and intimacy on the other.

3.8.5. Comparative findings – Theme 7 (Desire for connection and affection of others)

As has been the case with previous themes, when comparing the respective music therapy techniques, it seems that Receptive Music Therapy techniques elicit feelings, awareness and desires. In the case of this theme, feelings of the loss of significant others, missing family, being alone and the loss of romantic love were elicited. Desire so see family members and the need for social connection and romantic love were all responses elicited by Receptive Music Therapy techniques. Active Music Therapy, using songwriting and improvisation provided the means through which to express love and feelings regarding family members.

When differentiating between diagnostic groups, both groups articulated similar sentiments such as being alone, loss of social connection, being away from family and expressing the desire for love and social

connection. The SS-group indicated difficulty in expressing feelings.

Table 3.14: Comparing music therapy techniques – Theme 7

Responses elicited by Active Music Therapy techniques	**Responses elicited by Receptive Music Therapy techniques**
Used song writing to express love for children Used song writing to sing a message to her child Express feelings of joy about daughter through improvisation	Feelings of being aloneFeelings associated with being away from family and friends Feelings of loss of significant others Feelings of loss of significant aspects of life Awareness of need for social connection Need to care for others Associations with family life Need to see family Desire to restore family relations Memories of family membersFeelings of loss of romantic love Desire for romantic love Need for love

Table 3.15: Comparison of diagnostic groups – Theme 7

Major Depressive Disorder	**Schizophrenia-spectrum**
Articulate feelings of being alone Articulated feelings associated with being away from family and friends Articulated tendency to isolate oneself Expressed desire to go home to family Expressed desire for social connection	Articulated feelings of being alone Articulates feeling neglected Expressed desire to go home to family Articulated difficulty in expressing feelings Referred to missing significant others Referred to loss of significant others

Referred to loss of significant others Expressed joy at prospect of seeing family member	Referred to loss of significant aspects of life Named attributes of significant other Used metaphor when for mother's love

3.8.6.

3.9. Theme 8 – Barricaded from being here, now

Expressed through this theme are references to the difficulties clients experienced being in the present moment during music therapy sessions. Examples from the data refer to the mind and difficulties with regard to memory, concentration and focus, particularly in the context of active music making. Statements also refer to the manner in which active participation in music assists with concentration and focus.

3.9.1. Difficulty in being here, now in music making (VA110, VA133, VA135)

Statements referring to difficulties with concentration and focus include: "*Ek kan nie te veel dink nie. As ek te veel dink en te hard konsentreer kry ek hoofpyn* – I can't think too much. If I think too much and concentrate hard I get a headache" (T17 1h), "*ek sukkel om te konsentreer* – I am struggling to concentrate" (T4 4e), "maybe I don't have any other thing that I'm worried about. I can concentrate on myself" (T7 5n).

Client D referred to the music eliciting difficult thoughts and associations: "something's going on with my mind", "just that my mind, eish. My nerves", "you know that I don't like jazz music because it makes me think, think, think", "most of the time eish I close my eyes and it makes me think" (D2 1l, D3 1t, D15 1b, 1c).

Additional references include: "my concentration levels haven't been so great" (G14 4j), "I'm worried about my memory, that it's going" (G4 1n), "It's sort of blank, because of all this trauma" (G4 1o), "hard to switch off" (G11 3b). He also stated ways in which music making was of benefit to him: "the mind wasn't really here, but it's here now" (G14 7h), "focusing on actually doing something with your mind" (G8 4q), "but actually making me concentrate", "so the more we do it the better it's going to become" (G14 4i, 4k) and "the more you charge your battery, the more you will fill your mind with new ideas and new spaces" (G8 4y).

Further references from the data suggesting music's benefit with regard to concentration include: "teach me to be in my mind" (J18 8d), "relax my mind" (J18 8e), and after movement activities the following comments

were made: “it was like watch what you do, look” (L14 2l), “good to concentrate, and think ja” (F14 2k, 2l), “*konsentrasie* –concentration” (Q13 7e).

3.9.2. Forgetting and remembering (VA111) (VR134)

This section presents difficulties clients experienced with regard to memory loss and remembering aspects of music therapy work. Data references include: cannot remember what was sung in previous session (M16 2a), did not remember vocal work from previous session (O15 2a), “forgot how to drum a bit” (P3 1j), “all the songs have gone out of my head” (P10 3d), when asked about the movement activity in the previous session Client S said “*nee ek kan nie onthou nie* – no I don’t remember” (S14 3a), when asked to start a rhythm on the drum Client T said “*ek kan nie onthou nie. Is dit met musiek of sonder musiek?* – I can’t remember. Is it with music or without music?” (T3 6a), fluctuated between forgetting and remembering the therapist’s name (N7 5j, N2 6a, N8 6l, N12 6g, N8 7m, S5 3n, N25 7i), “no I’m not going to forget” (N8 7n), “*ek kan nie meer onthou want ek was 'n kind gewees. Lank jare terug* – I cannot remember anymore because I was a child. Many years ago” (Q25 7l).

As stated in the previous session too, Client G referred to concern that he was suffering memory loss (G19 1w).

3.9.3. Comparative findings – Theme 8 (Barricaded from being here, now)

When comparing the respective music therapy techniques, it was Active Music Therapy that both elicited an awareness of concentration difficulties as well as promoted opportunities for focus, concentration and inter-personal awareness. Concern about memory loss was articulated within both receptive and Active Music Therapy. Reference to not remembering as far back as childhood occurred during a Receptive Music Therapy technique.

When comparing diagnostic groups, both groups refer to difficulties with concentration. In the case of the MDD-group reference was made to music eliciting difficult thoughts and concern was expressed with regard to memory loss. In the SS-group, memory difficulty was experienced with regard to remembering the therapist’s name, music from previous sessions, what was required musically and recalling a memory from

childhood. It was also articulated that watching and playing assisted with concentration.

Table 3.16: Comparison of music therapy techniques – Theme 8

Responses elicited by Active Music Therapy techniques	**Responses elicited by Receptive Music Therapy techniques**
Awareness of concentration difficulties Focus and concentrationaAwareness of an-other Awareness and concern about memory loss Energy and fills mind with new ideas	Difficulty remembering back to childhood Concern about memory loss

Table 3.17: Comparison of diagnostic groups – Theme

Major Depressive Disorder	**Schizophrenia-spectrum**
Referred to the music eliciting difficult thoughts Referred to difficulty with concentration Refers to music assisting with focus Expressed concern over memory loss	Articulated difficulty with concentration Referred to the fact that watching and playing helped with concentration Difficulty remembering musical material from previous session Difficulty remembering what to do Difficulty remembering therapist's name Referred to difficulty remembering back to childhood

3.10. Theme 9 – Tensing and un-tensing

Included in the music therapy intervention was a relaxation component at the beginning of every session and a movement activity during the course of the first seven sessions. These components made clients aware of their physical bodies. During these, and with reference to other aspects of the sessions, clients made reference to physical bodily experiences, tiredness, stress and tension and the experiences of calming through the various music techniques. These four areas will be discussed with references from the data.

3.10.1. References to physical bodily distress and ease (VA21, VA22, VA56, VA64, VA92)

Clients remarked on how their physical bodies were responding to musical engagement. The responses in this sub theme all pertain to the Active Music Therapy component of the intervention. Firstly, clients commented on areas of bodily distress and pain: "I'm tense, I can feel it" (A2 3b), comments on hands being sore at the end (after drumming) (B4 1l, T4 4k), "My neck eish especially the head", "my headach", "my head is burning" (D3 1t, 1b, D8 5c) (D2 5a), referred to body being painful (G2 1c), dizzy after breathing exercises (G2 1e),"ow"-referring to muscles, "ja, but more on my neck and shoulders and in my back", "a little bit tiring in the back but it"s ok" (G2 2b, G2 1f, G12 5m), "no, just painful" (G12 5b), complained of sore back (H4 1e), complains of headache (H3 7g),"*my hande raak seer* – my hands get sore", "*jissie my rug* – jissie my back ", apologises for shaking (H3 6i, H12 7g, H14 2b), indicated arms were sore and tired (N14 3l), indicates difficulty dancing due to sore hip (R12 1a).

Clients also commented on exercising. Comments included references to the hospital as well as the need for and benefit of physical exercise. Four clients referred to the fact that there is no exercise offered on the wards (E2 5e, G2 1b, O12 1e, Q2 3f). One client acknowledged that he should be exercising but does not "I'm supposed to, but no" (B2 1l) and, in the context of exercising, referred to her weight: "I can't gain weight" (E2 2f).

Comments relating to the benefit of physical movement include: "though the muscles are stiff I get the flow", "I like the soothing music, and then to do that you can feel your body responding to the music" and "also, gets your body moving"(G12 3j, G14 4h), "very nice to bend down, yes.", "Yes I feel it" (J14 3f, J12 6h), reference to relaxation as "good for my body", "*voel baie good* - feels very good" (N2 2d) , "ja very nice, I exercise" and acknowledging therapist's comment regarding music giving him something active to do said "do something, ja " (N8 5y), " *dis soos "n sielkundige vir my. Want ek kry oefening* – it"s like a psychologist for me, because I'm getting exercise" (Q12 5i), states that her body felt calm during the mirror image exercise (S14 2j).

3.10.2. Tiredness (VA23, VA51) (VR109, VR110)

Apart from references to pain and bodily discomfort, clients made reference to being tired and lethargic which related to their own physical state as well as to how they felt as a result of engagement with music making and listening.

References to tiredness and lethargy with regard to personal circumstances and physical state include: "ja I had to go on, no matter what, no matter how I tired I am" (A8 2l), "that feeling of being drained" (B19 1f), "*my bene is verlam*- my legs are lame" (C12 1c), "it's the medication, the doctor said she is going to stop the treatment" (E2 3e), "Yoh, I"m slow today" (G7 3l), "*ek voel verlam* - I feel lame"(H2 6g), I'm a liitle bit tired because I played with the guys soccer" (Q2 4d), *"ek wil net slaap* – I just want to sleep" (T26 8l).

References to tiredness in relation to the music include: "music made me feel drained" (B19 1c), Client H who presented as lethargic during most of the music therapy process said, "*Lekker slaap musiek. Raak aan die slaap* – Nice sleep music – I'm falling asleep*" (*H2 7a) and in relation to having to extend herself by playing numerous instruments in the music space: "*hoe gaan ek alles speel, ek het net tee arms"* – how am I going to play everything, I only have two arms" (H8 7a), stated that his arms were sore and that he tired after a while (N14 3l, 4e), "I was very tired. I'm refreshed now" (P15 3k).

3.10.3. Telling about being stressed and tensed (VA07, VA45, VA46, VA112) (VR19, VR35,VR76, VR136, VR175)

Numerous references were made to feelings of stress, nervousness and anxiety. These responses were in the context of both Active and Receptive Music Therapy techniques.

3.10.3.1. Anxiety

Referring to the colour black in an image said it represented "heavy, anxiety, moody" and stated also that

she experiences anxiety (A20 2g, 2m), "alone, angry, isolated, disconnected, anxious, tense and that is why I am frustrated" (F26 8f), "ag it's just you live with these anxieties" (G2 1g, G19 1e), "*baie angst* – very anxious" and said "*Oo ek bewe so*- I'm shaking so much", "*ek bewe* – I am shaking" (H6 2v, H8 2j, H2 3b), experienced a difference in the anxiety through drumming (H11 2i).

Client I (MDD) with a co-morbid diagnosis of Conversion Disorder which manifested in anxiety-induced frozen speech, referred on numerous occasions to the anxiety she experiences: "Horrible, like I have no control in that space", "affects my speech" (I20 2h, 2i). Whilst reflecting on images or music which evoked feelings of anxiety she would respond as follows : difficulty with speech when client reads emotions she has written, speech slowed down when story was read, speech slows down when reflecting on isolation, struggling to sing due to frozen speech (I21 3l, I23 5b, I25 7q, I15 1b). She also commented after a conversation reflecting on the manner in which the intensity of her drumming seemed to resonate with her intense feelings of anxiety: " I've experienced that when I get angry the anxiety goes down" and "Ja, it makes sense because when I get angry the anxiety goes down" (I11 2a, 2e).

There were two references to music eliciting anxiety: reported that the music made her feel anxious (S14 4h), "*alles kan sien maar klop my hart "bietjie*- I can see everything but my heart is beating a little", "*ek gaan heen en weer* - I'm going to and fro" (T11 6e, 6f).

3.10.3.2. Stress and tension

References to stress and tension include: "always feels tense" and does not feel calm often (E19 1g, E19 1f), "I'm feeling stressed, that's why I came hospital" and "I was very stressed when I came here" (J19 1e,1m)" "*ek voel baie stressed* – I am feeling very stressed" (N26 8d), referring to auditory hallucinations said " To make for me stress" (O19 1e). She also said "I feel stressed. In a technique requiring the client to select a word describing how she feels, Client O chose the word stressed: "To my problem. I want to stay Pietersburg. Maar as ek go to Pietersburg the stress is finish" and "My stress, I'm still at hospital" (O26 8c, 8f).

Client Q, during a Receptive Music Therapy technique that comprised selecting a word from a wide variety of words placed on the floor in front of the client, chose the words 'stressed' and 'open'. When asked to

describe his choice of the word "stressed" he said: "*As ek mondelings doen. as ek moet baie praat. party van die pasiente wat dinge agter my rug se. dan glo hulle nie wat ek alles se. Nie almal is aan my kant nie* - if I have to do it verbally , if I must talk a lot, some of the patients that say things behind my back, I don't believe them. Not all are on my side" (Q26 8d).

The following clients referred to the benefit of music in relation to stress: after an instrument improvisation said: "I forgot the stress" (O26 8k), drumming experienced as a stress release (F11 1m, H4 1g, H12 1h), "when I play the drum the stress is gone" (O11 8i).

3.10.3.3. Nervousness

Referring to the vocal component of Session 1 Client A said "I was so nervous" (A17 1ui) and with reference to taking steps towards her future says "Mm, Ja and although nervous but I can see" (A23 5u), Client indicates with a gesture to her head that the music is loud and acknowledges that it is linked to her nervous condition (D3 1t, D4 1m, D4 1l). Client T referring to attending the first music therapy session said "*Ek was heel op my senuwees* – I was very nervous" (T8 1o) and with reference to his general state of being said "*ek is senuweagtic vandag* – I am nervous today" and "*Ek was op my senuwees. Ek voel "n bietjie beter* – I was nervous. I feel a little better" (T14 4b, 4k).

3.10.3.4. Calming (VA09, VA10, VA12, VA24, VA26, VA25, VA27) (VR104, VR188, VR135,VR163)

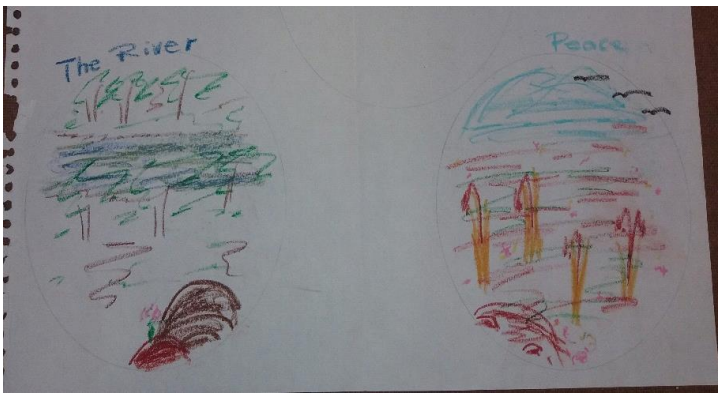

Image 3.12. (Client R - SS, Session 7 – Calming)

"Relaxing on an island. The sun's going down, on an island", lullaby, "room in Balito", being far away at the sea, nature scene and the river are examples of imagery elicited by music listening which promoted feelings of being relaxed and calm (F19 1c, P19 1f, G24 6b, H19 1a, R25 7a, 7c – Image 3.12).
This sub - theme's data references will be presented according to the two music therapy approaches, i.e. Active and Receptive Music Therapy respectively:

3.10.3.4.1. Calming through Active Music Therapy

Different components of Active Music Therapy facilitated experiences of relaxation and calming. Examples from the data cite references to different aspects of active music making. Relaxation component: "felt so peaceful" (A2 2l), "*Want ek haal nie diep asem nie. Ek moet leer om diep asem in te haal* – because I don't breathe deeply – I must learn to breathe deeply) F2 2i), reported being dizzy after breathing exercises (G2 1e) which may have been an indication of using his breath more deeply (G2 1e), "everything calming me down", "feel calm" (L2 2g), "feels fine" (O2 2d, Q2 7d), "I felt good" (E2 8d), "Ja ek relax. Relaxing. Very relaxed. More relaxed" (F2 2h, F2 3f), "felt relaxed" (G2 7f), "relaxing (I2 1g, L2 2f, O2 3c, P2 1f, P2 2c)), "I'm feeling ok" (M2 1g), "*rustigheid* –restfulness" (H2 8d).

With reference to drumming two clients commented: "I feel a little bit loose" (A3 3q), and feeling more comfortable (H3 1j). Instrumental improvisations, which included themed and vocal improvisations elicited the following responses: "*jy maak my op my gemak voel* - you make me feel comfortable" (T8 1p), "a bit calming considering what I've been through these two days" (A8 6ao), "I'm feeling more calm, ja" (A11 6r), "wow, this is so nice. Brings out I such a subtle, calm way" (I11 4k), "*ek voel veiliger by die donkerte, die sterre is liggies*" – I feel safer in the dark, the stars are lights" (T11 6h), "I experience that I become, I take a deep breath, feel release" (J11 3j), Client E chose the theme of comfort for an improvisation based on her experience of the movement activity (E11 6a, 6j), "it's peaceful, feel the love, I have a feeling" (E11 3f), "and the calmness" (G15 3p),

Responses to the movement component include: "feel peaceful" (D12 5j), song (You Raise Me Up) brought comfort" (E12 6j), "like the soothing music" (G12 3i), experienced music as calming (I14 3g), body felt calm during mirror image (S14 2j). Client O (SS) reported feeling "well" after movement activity (O14 3f).

3.10.3.4.2. Calming through Receptive Music Therapy

Receptive Music Therapy techniques elicited varied responses from clients partially due to the range of music employed and symbolic material evoked. Responses included actual and desired feelings of peacefulness, calm and being relaxed. Examples from the data include: "how I want to feel – relaxed" (F25 7m), "peace, tranquility, relaxation" (P21 3c), "I feel that I relax" (Q20 2e), Client T (SS) referred to the music making him feel restful and important (T19 1h) and felt restful and experienced love when the music played (T20 2i), "it makes me relaxing" (F19 1d), other clients referred to feelings of calmness and relaxation (F21 3c, Q19 1e, Q20 2e, Q21 3d), it makes me calm (F21 3e), "calmness in me" (G19 1t), visualised a calm evening (G21 3f), stated: "*ek voel meer kalm* – I feel more calm" and "*die musiek maak my kalm* – the music makes me clam" (H23 5g, 5p), visualised the symbol of a deep breath which assisted in calming her (I21 3cvi, I21 3o), referred to the music as "nice and soft and I feel calm" and "I'm feeling better now, I'm feeling calm" (J19 1c,1d), "it soothes us" and she assigned "Calming sadness" as a title to an image she drew; referred to the music making her "restful and clear" (S19 1h), Client R wrote a poem in session 3 (Image 3.13) articulating her desire to experience peace again:

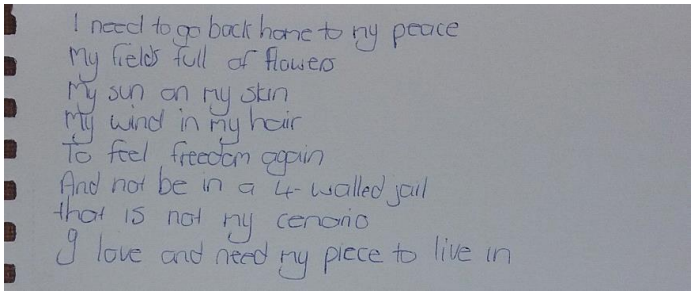
I need to go back home to my peace
My fields full of flowers
My sun on my skin
My wind in my hair
To feel freedom again
And not be in a 4-walled jail
that is not my scenario
I love and need my piece to live in

Image 3.13. (Client R - SS, Session 3 – Poem text)

3.10.4. Comparative findings – Theme 9 (Tensing and un-tensing)

When comparing the respective music therapy techniques, Active Music Therapy elicited awareness of physical ailments, tiredness and various challenges, and afforded experiences of relaxation and calming, stress and anxiety relief and feelings of wellness. The benefits of exercise were articulated. Receptive Music

Therapy on the one hand elicited feelings of anxiety and being drained, references to emotional tiredness and past feelings of stress whilst on the other hand affording experiences of relaxation and calming through music-evoked imagery.

When differentiating between diagnostic groups, there were similar responses from the two groups regarding references to limited opportunities for exercise on the wards, the benefits of exercise, feeling stressed, being nervous at the start of music making, music inducing anxiety, drumming as a stress relief, feeling good after active participation and references to imagery linked with relaxation. The MDD-group displayed greater awareness of physiological and emotional states with reference to physical ailments, tremor, frozen speech, stiffness, emotional tiredness and feeling drained.

Table 3.18: Comparison of music therapy techniques – Theme 9

Responses elicited by Active Music Therapy techniques	**Responses elicited by Receptive Music Therapy techniques**
Awareness of physical body after relaxation, movement and drumming References to physical ailments Benefits of exercise and being active No other form of exercise Movement experienced as calming Relaxation as sleep inducing Shift from tiredness to being refreshed Tiredness and slow due to medication Difficulty singing due to anxiety Anxiety matched by drumming Anxiety relieved by drumming Feelings of anxiety Benefit of music making for stress Nervousness to partake in music making Calming and relaxation effect Feeling comfortable Peaceful and soothing	Experienced music as draining Emotional tiredness Feelings of anxiety Current feelings of stress Recalled past feelings of stress iImagery associated with relaxation and calming Relaxation Calming sadness

Awareness of breathing Release Wellness	

Table 3.19: Comparison of diagnostic groups – Theme 9

Major Depressive Disorder	**Schizophrenia-spectrum**
Awareness of tension in body Commented on pain in body Commented on stiff body Referred to tremor and shaking Indicated that he should exercise but doesn't Highlighted no exercise on ward Referred to weight Benefit of exercise Feeling good Experienced as soothing Tiredness Lethargy and being slow Emotional tiredness Music as sleep inducing Used metaphor to describe anxietyFrozen speech Reflected on anxietyFeeling stressed Drumming as stress release Nervous for music making Experienced imagery associated with relaxation Music as calming Awareness of breathing	Highlighted no exercise on ward Referred to benefit of exercise Articulated feeling good Regard movement as therapeutic Articulated shift from being tired to being refreshed Experienced body being sore after drumming Music making induced anxiety Articulated feeling stress Drumming as stress release Stated being nervous for music making Imagery associated with relaxation Comfortable in music making Feeling well after movement Iimagery associated with calming Experiencing peace

3.11. Theme 10 - Relating to musical expression

Clients came into this course of music therapy each with their own relationship with and personal experience of music. Most did not have prior musical training. Some had participated in music making at school, or at some stage during their life but without any formal training. Some enjoyed listening to music

and stated musical preferences but had never participated in any form of music making. Clients, thus, related to music making in different ways. This theme is expressed with reference to i) non-acquaintance and novelty of music making, ii) reconnecting with previous musical experience, iii) personal identification with music preferences, iv) exercising choice in music making and v) discomfort with own voice in singing.

3.11.1. Non-acquaintance and novelty in music making (VA35, VA36, VA61, VA67, VA68, VA131)

Some clients indicated no previous knowledge or experience of music making. The novelty of making music, thus, elicited varied responses. Examples from the data include: "I haven't got a cooking clue about music but I tried" (G8 4v), indicated that she is "stupid" with music" (R8 5d). Clients commented about this being their first experience of music making: " ja, it's my first time", "I've never done it like that before", "*Ja, die eerste keer* – yes, the first time", "this, ja – first time playing djembe drums", "*nog nooit nie* –not ever before", "*dis die eerste keer dat ek hierdie instrument speel* – it's the first time I have played this instrument" (A8 1z, A143m, C81v, F3 1v, H3 1a, T8 1n).

Comments also reflect clients" first experiences of music making: "Strange, odd. Yes, it is different" (B8 1s), "It was different and nice" (E8 5x), Client F, although a professional musician in the past, experienced this form of music making as "something new", "easier but still a new experience", "something new for me" (F14 2j, F5 3z, F12 6g), "it doesn"t come naturally" (B8 1t), "I'm proud because I didn't play this before" (D8 5y), Client H did not realise she had a talent to sing (H15 2e), "no, it's my first time. I found it interesting. Enjoyed it" (Q8 1i), "no I don't listen to music" (R8 3c), "no I don't know that one" (N5 3a).

3.11.2. Reconnecting with previous musical experience (VA57, VA58, VA59, VA118) (VR172)

For some clients music making was not an entirely new experience, even though they may have experienced this form of music making as something novel.

Three clients indicated previous experience of drumming (B3 1a, P3 1k, L4 ij). Client I indicated having "fooled around" on the drums (I3 1a) and that the drum was used to imitate a storm in the choir" (I8 1b). Client I also referred to having previously danced before and was acquainted with the song "You Raise Me Up" chosen as a choreography exercise within the music therapy intervention. (I12 6b, 6f). Client L referred to having sung in a choir previously, performed with friends and doing R&B dancing (L15 2a, 2b, L14 3l), Clients R and S both referred to having danced previously (R12 1e, S12 1b). Client J said that she had not danced for a very long time (J14 5g) and Client P said she hadn't drummed for a "very, very long time" (P4

1f).

Clients displayed an interest in various aspects of music making and indicated an interest in future involvement: " Yes, join a choir" (E15 2j), "I think I want a drum" (I11 8i), "yes I want to learn more about the drum" (L3 2l), displayed an interest in learning to play the piano (M8 1f), requested the therapist to write down the words of a song that had been co-improvised: "write the words I want to practice" (O11 8d).

One client, Client F, had worked as a professional musician in his younger days. He had previously played the drums, bongos, percussion, the guitar and the marimba (F3 1a, F3 1w, F15 1c, F8 6w). He shared that in his younger years he had been too shy to perform for others, but would write songs at school and sing to his friends, and they had loved it (F19 1t, F21 3l). He reflected on the fact that he had "been out of it for so long" having been used to playing in front of audiences (F24 6m). As the sessions progressed he connected more and more with his previous musical knowledge and experience. He began playing the guitar again: "I love it", "out of practice", "good to play again"," my fingers don't work so well" were some of the comments he made after we incorporated the guitar into the music therapy sessions (F16 3r, F15 4l, F15 4m, F15 5l). He also indicated that it had been years since he played the piano (F15 5m). The music therapy sessions seem to renew his interest in connecting with music as a musician. Whilst he stated that he needs more confidence (F15 5p), he, nonetheless, began teaching a fellow patient on the ward (F15 5n). He expressed his enjoyment about the music (F15 5o), and piqued interest by requesting a bass guitar to be included in the sessions (F8 6z).

The music therapy process enabled Client F to reconnect with the musician within him as well as providing a means through which to express himself.

Audio clip B – (Track 22 Blues guitar) is an example from session six, of Client F playing a bass line on an acoustic guitar. Therapist and client improvise a Blues chord sequence. This is the first time, according to Client F, that he is playing the guitar in this manner for many years. This audio clip illustrates the client's willingness to try, the manner in which he naturally remembers the basics of the Blues scale, and the ease with which client and therapist jointly negotiate the music.

3.11.3. Personal identification with music preferences and familiarity with musical expression (VA55, VA60, VA63, VA115) (VR132)

Client and therapist meet in music each with distinct musical preferences, bringing personal, cultural, spiritual and linguistic identification to the music relationship.
Comments related to music preference include: “no favourite genre” as he enjoys a “wide range of music” (B2 1c, 1d), “does not listen to jazz” (C15 1b), “I don’t like jazz, because it makes me think, think, think” (D15 1b), expresses enjoyment of the Blues (F8 1l), “Neo. The old, not his new stuff. Adele, ja, everything” (I12 1b), “mostly I like to sing gospel songs” (P16 1a), indicates that he enjoys Gospel music (Q15 1a).

Clients brought music familiar to them as suggestions for inclusion in the music therapy sessions: trying to remember a song he knows (G4 1m), client chooses song which has spiritual significance (J11 6a), in the final session (a week before Christmas) Client J brought a musical gift for the therapist. These were three songs from her spiritual and cultural heritage: “God be with you ‘til we meet again”, “I wish you a merry Christmas” and a traditional Zulu song (J16 8b, 8c, 8d), requests “Over the rainbow” (L16 3a), recognises a Zulu song introduced by the therapist and indicates his preference for gospel songs (M15 1b, M15 1i), more comfortable with music familiar to him than improvised music. He sang church hymns and one particular pop song which was regularly sung during sessions (N15 2a, N5 3i, N12 5a), requested “Die Heer is my herder”, an Afrikaans hymn.

Along with identification with familiar music came personal identification with language and culture as expressed in clients’ musical contributions: “Ja, but the Zulu language” (D15 1e), Initiated Zulu song appropriate to theme (D10 2e) and indicated: “I’m not good in English” (D21 3e), sang “Rock of Ages” in Sotho (J8 1e), changes instruments and sings Zulu song reflecting themes of tears and joy (J8 5f), sings Afrikaans song from her days as a domestic worker (J8 7e) and explains that she was depicting a ritual associated with a traditional wedding during a movement activity (J12 7g), wrote her story text in Zulu which was translated for the therapist afterwards (J23 5b) (See Image 3.14), sings a Sotho song which is translated for therapist (O16 1c, 1e) and translates a traditional religious Sotho song in the following session (O16 2c), names an Afrikaans song (Q8 2g), refuses to play the djembe drum from the third session: “I don’t want to play because it’s skin of cow “(M3 3a)

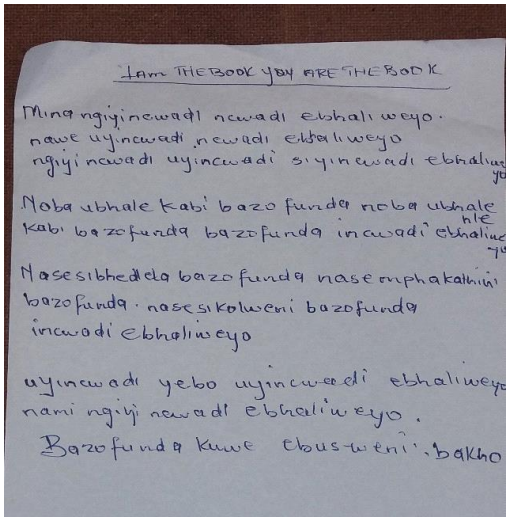

Image 3.14. (Client J - MDD, Session 5 – Story text in Zulu)

3.11.4. Exercising choice in music making (VA31, VA66, VA113)

As the music therapy sessions progressed, clients began to exercise choice and preference in terms of instrument selection and engagement in musical processes. At times clients provided a rationale for choice of instrument whilst at other times instruments were selected based on the available choice: starts with "easiest" instrument (B8 1c), chose drumming as own choice for final session" (E3 8a), instrument preference tambourine and woodblock (F8 2s), "definitely drums. Something that can make a noise" (F11 7i), "always enjoyed when you either played with the guitar and me sort of hum along" (G15 8a), chooses to play the conga drum (I11 4b), asks: "can I use the drum?" (I11 5c) chooses rain stick for "Challenges" theme – "irritating sound" (P11 7c), selects tambourine for "strong woman" theme (P11 7d).

Instruments of preference included: "windchimes" (H8 4i), "I love this one" (referring to small shaker) (I8 3n), enjoyed all the instruments (J8 4n), prefers woodblock – "I realise it has different sounds" (P8 1j), indicated preference for the xylophone (P8 5n), the tambourine (Q8 1h), the djembe drum (Q3 4o), the piano (S8 1o) and djembe over conga (T4 4l).

The above-mentioned examples illustrate ways in which clients began relating to aspects of music making expressing individuality through choice, participation and preference.

3.11.5. Awareness of and discomfort with own voice in singing (VA106)

The final sub - theme is expressed through references to discomfort and shyness when relating to one's own voice in music making. "*ek's klaar hoarse – I'm already hoarse*" (C15 1r), although a musician himself found the vocal aspect of the music therapy sessions uncomfortable "no not my voice", I'm thinking I would rather do it on the piano", "Ag no. I hate it.", I'm actually scared of my voice. Don't know why?" refers to own voice as boring. He did display willingness to try vocal work with a song that suits his voice (F15 1p, F17 1c, F15 2a, F15 2i, F5 3u, F15 5i, F15 2t), when complimented on the use of her voice; indicated that she did not know she could sing (J15 2j), *"ek is te skaam* – I am too shy" (T15 1f) and stated that he sings false if he does not sing with someone (T15 2i) and in session 3 said "*ek het nie lekker gesing nie* – I did not sing well" (T5 3h).

Other references to voice include: feels difference in his voice "Yes I can feel it" (G15 3m), "I'm chanting now", "singing, can I sing it?" (I11 7c), "I like to sing" (O16 1a), "*Kan ons "n bietjie sing?* – Can we sing ?" (S15 1a), aware of voice being louder (S8 8r), "*Ja ek sing laag note* –yes I sing low notes" (T16 4j).

3.11.6. Comparative findings – Theme 10 (Relating to musical expression)

This theme emerged from Active Music Therapy techniques exclusively. References to musical expression range from statements revealing no or limited prior musical experiences to varying levels of prior music experience. Other references included discomfort in music making, exercising choice and leadership in music making, reconnecting with music and personal identification with music which was expressed through preferred genre, language and cultural expression.

When comparing the two diagnostic groups there were similar responses with respect to previous musical experience, music making as a first time experience, indicating preferred genre and instruments of choice, initiating music in own language and awareness of singing voice. Differences include a reference in the MDD-group to discomfort using the voice to sing whereas in the SS-group enjoyment thereof was expressed. The MDD-group included a reference to a specific genre of music evoking difficult associations. In the SS-group there is a reference to a client's refusal to play an instrument on spiritual grounds.

Table 3.20: Comparing music therapy techniques – Theme 10

Responses elicited by Active Music Therapy techniques	**Responses elicited by Receptive Music Therapy techniques**
Nervousness with regard to no prior musical training Making music for the first time Music making as new experience Music making as strange Reference to previous musical experience Interest in ongoing musical participation One client previously professional musician Reconnecting with music Musical preference Personal identification with music Associated with cultural aspects of music Brought own language and cultural uniqueness to music Opportunities to exercise choice and leadership Traditional cultural expression Awareness of discomfort in music making	

Table 3.21: Comparing diagnostic groups – Theme 10

Major Depressive Disorder	**Schizophrenia-spectrum**
Referred to not knowing how but trying Reference to being first time Previous experience drumming Previous experience dancing Previous experience in a choir Professional musician – reconnecting with music after a long time Associated specific genre with difficult memories	Being stupid with music Reference to being first time Does not listen to music Previous experience drumming Previous experience dancing Articulate preference for specific genre Gospel music and hymns Refusal to play instrument on spiritual grounds

Articulate preference for musical genre Initiated singing 3 songs for therapist as parting gift Initiated music in own language Initiated music in own cultural expression Exercises choice and leadership Indicated instruments of preference Discomfort with singing Noticed change in singing voice New awareness of singing voice	Initiates music in own language Uses instrument symbolically Indicates instruments of preference Enjoys singing Awareness of voice pitch Awareness of louder use of voice Reflection on not singing well

3.12. Theme 11 – Reflections on the music and music making in the therapy

"*Ja I was talking to the psychologist the other day it's like I'm finding out the other part of me that I didn't know, and she said how? I said, through music. It's like the other part of me was inside, it was not yet..I never realised it. It was there, what do you call it, unconsciously. So it's like it's been revealed***"** (A23 5af, 5ag).

Theme 10 referred to varied ways in which clients related to music making. Theme 11 extends this and draws from examples in the data to illustrate ways in which clients reflected on active and receptive music processes. This theme is expressed through i) clients' spontaneous commenting on music making, ii) heightened awareness and appreciation of the music, iii) recalling significant life-event memories and iv) metaphorical reflections on affordances brought about by the music therapy.

3.12.1. Spontaneous commenting on music making (VA34, VA37, VA40, VA65, VA76, VA78)

Within the music therapy intervention every effort was made to keep the client central to the process. Clients were encouraged to offer ideas, take the initiative, make choices and reflect upon musical processes.

The data indicate clients' comments with reference to offering musical ideas, initiative and complimenting the therapist. Examples from across the spectrum of clients include: "should be very slow..something soft" (A11 1b), suggested peaceful music to fit theme (E11 4b), chose instruments for self and therapist (E11 7b), "I will start with this just to hear what you are playing" (F8 3d), suggested "House of the Rising Sun" (F16 3a),

suggest “Kumbaya” (H15 3a), introduces theme for improvisation – storm (H3 8e), chooses to sing “Let it Go” (I11 7b), other song suggestions (M5 4a, M8 7b, N15 3a, Q15 2d, Q15 3a), suggested words for an improvised song (O11 5b), named a piano improvisation “*Die Swerwers*- Vagrants” (S8 3k), requests “Let it be” (S8 8b), initiated words and melody from nursery rhyme (T8 2d).

Examples illustrating initiative include: “Can I put away the instruments” (I8 7l) wanting to change instruments “can I change to the other?” (A8 1f), remembering a 3 rhythm exercise from the previous session enquired: “are we going to play the waltz?” (E8 3r), requested writing more words on an image (H11 7f), “can I say the words and not sing” (I8 8b), asks for song sheet with words (S8 1a) and requests “vibey” music for the dance (S12 8a).

Examples of spontaneous reflections after music making include: “ja, now I can listen and do, unlike that time I was just doing” (A8 3y), “following somebody”s direction” (A14 2g), “it was like watch what you do, look” (L14 2l), “*Ek het luister daar wat jy daar speel. Toe ek baie kleiner was het my ouma “n orrel gehad*- I listened there to what you played – when I was smaller my grandmother had an organ” (C8 1x), “you are very good” (B8 1p), commenting on the music used for relaxation: “dis mooi hierdie, hoor”(F2 2g), “you sing good man. You can play any kind of song I think (K8 1h). More detailed reflection of the music will be included in the following sub- theme referring to clients’ appreciation of aspects of the music.

3.12.2. Heightened awareness and appreciation of music (VA38, VA39, VA79, VA86, VA114, VA130, VA106, VA107) (VR108)

This sub - theme refers to data examples expressing heightened and more detailed awareness of aspects of the music. Comments include recognition of familiar music, reference to specific musical elements and awareness of own music. Examples from the data include: “Starry, starry night?” (F2 2a), “Misty. Ja of course. Beautiful, I love it” (F2 5g), “That’s a nice chord. It’s an A6” (F15 1b), “I love those chords” (F17 1m), “you play some nice song on the piano” (M8 1e), “heard the sounds of the guitar and the violin” (Q20 2f), “it tells a story where the music changed” (T21 3c), commented on electric guitar being strong (T21 3e).

With regard to musical instruments and specific elements such as pitch, rhythm, dynamics and tempo the comments included: “ it’s too high for me” (F15 2n), “no, too low” (F15 2r), “oh we make the music louder and louder” (J11 3f), identifies the bird sounds in piece of music (O2 8c), prefers woodblock – “I realise it has

different sounds" (P8 1j), "the softness and the quietness" (P14 2j), aware of voice being louder (S8 8r), "*en hierdie is sag met die klaviernote* – and this is soft with the piano notes" (T8 4h),referring to African music: " *Lekker* (Nice)… They've all got that lovely rhythm. I love it" (F12 5i), instruments too loud (D8 1s), suggests music should be soft (E11 6b), suggested music to sound soft (E11 7c), "Am I going to play the stick with the tambourine" (D8 4c), how do you play this? (E8 4o), referring to the Conga: "it's nice to play on" (G3 4s), experiences xylophone as interesting (G8 5l, and showed interest in the guitar (H15 1a).

It is important to highlight these specific references to the music. Most clients, due to the effects of mental illness and medication, such as blunted affect and disorganisation, are shut off from nuanced detail and being able to regulate expression. Two such examples from the data include: did not recognise sounds as coming from the music (M2 8c) and when asked whether client had noticed the fact that the therapist introduced intentional "stops" in the music Client P (SS), "I didn't realise" (P3 5d). What might be taken for granted from someone with musical knowledge and experience does not apply to these clients across both diagnostic groups.

3.12.3. Recalling significant life-event memories (VA103, VA140) (VR60, VA140, VR112, VR113, VR 133, VR170)

Receptive and Active Music Therapy techniques elicited imagery, associations, emotions and memories of varied subject matter. This sub-theme is presented with reference to significant life-event memories evoked by the music.

Images evoked through music listening which represented specific life memories include: "Jersey, T-shirt and a ball representing playing netball at school and clothes items representing what she left at home" (O24 6b), a "watch" representing what had been purchased with his salary when he still worked (M24 6c), figure of a female representing a previous relationship (M25 7e, 7h). He also recalled his working days and a truck accident which had resulted in his permanently damaged leg (M23 5g, M26 8f), Visual, male figure, car and watch representing for a time when he played soccer and the car associated with his sister,(N25 7b), the image of a figure and the kraal was linked to specific memories of her grandfather on the farm (O22 4b, 4e), images relating to the birth of her children, her studying and working years (Image 3.15).

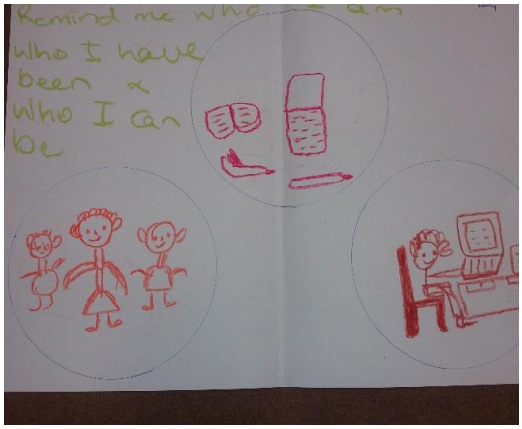

Image 3.15. (Client P - SS, Session 7 – Life-event memories)

Other memories and life events associated with music listening include: “turned back on family” (A21 3w), image representing her son who she seldom sees (C19 1f, 1h), “I know where I come from” and related being separated from her siblings, having a conflicted relationship with her sister, and talked about her relationship with her aunt and uncle in her formative years (J22 4m, J20 2j, J21 3l, J25 7j), recalled traumatic events, wished to escape the memories (G15 3q) and on the other hand recalled days during which he achieved in his specific sport (G21 3g), two clients recalled an affirming memory both having been acknowledged by late president Nelson Mandela: “I remember that day, I will not forget it” (D23 5e), “That was a moment I will never forget” (F25 7i), recalling memories which “belong to me” juxtaposed with the impact of trauma (G25 7a,7c – Image 3.16a), associating an image with her mother who had passed away (Image 3.16b), of whom she said “ if she were still alive I would not be here” (D20 2aa).

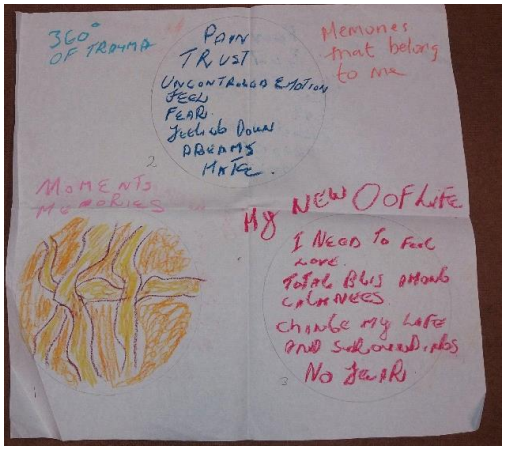

Image 3.16a. (Client G - MDD, Session 7 – Memories that belong to me)

Image 3.16b. (Client D - MDD, Session 2 – Life-event memories)

"Something broke me – from there it went down" (B19 1i), stating that his life changed after he left his first job (F25 7x), recalled her mother's traumatic death (P24 6h), disclosed very personal information following a drumming improvisation: "*Ek vertel jou iets baie persoonlik* – I'm telling you something very personal (T3 1j) and, after an improvisation based on the verbal processing following the Clay music technique, said "*ek het te veel sonde in my lewe* – I have too many sins in my life" (H11 4g).

It is clear from these examples related to specific life events, that music elicited painful and difficult memories as well as memories that brought affirmation and re-connection to self.

3.12.4. Metaphorical reflections on affordances and connections brought about by the music therapy (VA96, VA98, VA120, VA139) (VR92, VR103, VR175, VR210)

The final sub - theme is articulated through imagery and insights elicited by the music in the form of symbol, metaphor and association. It includes clients" reflections on how the music touched them internally and how new insights were gained through working with music through the language of metaphor.

Client G said, in session 4 "you're always dwelling on the past and the trauma and the depression. Creating new spaces and ideas, it actually creates more brain capacity that hasn't been used in the past,.., the more you charge your battery, the more you fill your mind with new ideas and new spaces, it's going to start suppressing the trauma and the depression" (G8 4z).

Firstly, clients referred to how music had impacted them personally at a more general level: “music touches”, “music changes on the inside”, “music opens doors”, “see life differently through music” (A28 8m-8p), “ *Tipe musiek wat ek sal luister om myself te vind alleenheid. Kalm, maar laat mens dink aan vryheid. Vind dit tog stimuleerend. Sal daarna alleen luister.* - the type of music I will listen to find myself, alone. It’s calm, but allows one to think of freedom. I also find it stimulating, but would listen to it alone*”* (F21 3b), referred to music making her “feel well” (O20 2d), brought her inspiration and motivation (S26 8h) and indicated a desire for music therapy sessions to continue (S8 8t), music therapy sessions making him feel good (Q23 5b) and assisting him with the expression of his emotions (T22 4t).
Secondly, the data illustrate specific examples of connections clients made between symbols elicited by the music and personal stories:

Client A (MDD) worked with three main themes. In session 2 she wrote: "How my life is. Full of ups and downs of. Not stable- I visit stability" "Not stable at all” (A20 2h, 2i). The theme that emerged was working towards being a resident of stability rather than a visitor. The second theme related to the baby/mama fish clay sculptures representing the impasse of dependency referred to in 3.3. The third symbol was that of a door: “The door is rusted but I pushed it to open it bit by bit” (A25 7g).

Reflecting on the music therapy process, she said “The mamma fish and the baby, I have to be exposed to other things that are difficult and I have to be strong, ja, like a mamma fish (A24 6ao), “I’m a resident. I’m next to this waterfall. Ja, I’m finally a resident”, “be a resident, no more a visitor” (A2 8i, A8 8u), “Ja, the door is open, no rust, it is open” (A2 8m). Image 3.10, in section 3.7.2 refers to an image drawn by Client A in which she gives expression to feelings of anger, but also acknowledges the need for “life to go on”. The text at the bottom of the image reads “Stronger than the pain” which she linked with the symbol of the “mama fish”.

In the final session I invited the client to reflect on the music process through an improvised songwriting activity. This description captures what followed and is illustrated by the **audio clip C (Track 23 – Client A (MDD) Stronger than the pain).**

“*She sings: walking, walking, walking walk even though it’s painful, I’ll be walk walking..na na na na na, na na na na na, I’ll be stronger than the pain, stronger than the pain, I’ll be stronger than the pain, I’ll be stronger than the pain, an improvised section follows with both singing using na na na , walking and*

stronger. Music has a jazz feel and part of the improvisation is in the form of call and response" (Client A, Session 8 (A18).

Other references to symbols and themes include: imagery of a storm "*wind waai, aardbewing* – wind blowing, earthquake" (H3 8g), "Theme- being raised up" (I11 6a), and referring to the symbol of a barrier representing her depression. Of this she said: "always have the barrier in my mind" (I23 5u), referred to a watch that he drew and said "*elke ding het sy tyd* – everything has its time" (N25 7h), "Yes I remember the tree. The big tree"…"I want to grow up like a tree" (O20 2h, O21 3d), reflecting on the sessions she said: "I remember happy. I remember my song. I remember the leaf (O25 7g), referring to the imagery of a rainbow and storm said "you will never be 100% in the sunshine with no rain" (P26 8q), likened aspects of his drawing to his mother: "*Die laaste een het almal so half omvou. Vloei deur al die musiek. Dis soos my ma, sy's soos suurstof, alles omvou* – the last one enfolded everyone. Flows through the music. Just like my mom, she's like oxygen, enfolding everything" (T20 2k) and from a story text he wrote on creation he said: *"so kan elke mens iets skep* – so can each person create something" (T23 5c).

3.12.5. **Comparative findings – Theme 11** (Reflections on the music and music making in the therapy)

When comparing the respective music therapy techniques both Active and Receptive Music Therapy techniques were said to have revealed unconscious material and different aspects of the self. A heightened experience of the music was indicated in both techniques and, in contrast, limited awareness of the music was referred to in Receptive Music Therapy. Symbols and metaphor are common to both groups, where feelings and personal story are associated with symbolic material elicited through Receptive Music Therapy techniques and further explored and reflected through Active Music Therapy techniques. Active Music Therapy was described as affording motivation, and agency seemed to have been experienced through clients' being active musical partners with the therapist. Receptive Music Therapy techniques elicited good and difficult memories related to specific life moments. Receptive Music Therapy elicited feelings of wellness and assisted with expressing emotion.

When comparing the two diagnostic groups, both groups indicated a heightened awareness of the music, initiated musical ideas and linked music with specific memories. The SS-group also indicated limited awareness of the music. Clients in MDD-group referred to music revealing unconscious material and referred back to symbolic material elicited during the music therapy process. Clients in the SS-group referred to music

assisting with the expression of emotions and articulated feelings of wellness and being inspired and motivated. Reference to symbols and metaphor were common to both groups whilst references to concrete objects and people associated with personal story are referred to in the SS-group.

Table 3.22: Comparison of music therapy techniques – Theme 11

Responses elicited by Active Music Therapy techniques	**Responses elicited by Receptive Music Therapy techniques**
Revealing unconscious material Revealing different aspects of self Suggested song choices Active musical partner Spontaneous reflections Heightened awareness of music Metaphoric description of music making Inspiration and motivation Use of metaphor and symbols in music making	Revealing unconscious material Revealing different aspects of self Heightened awareness of music Limited awareness of music Recall of specific life memories Recall of difficult memories Recall of pleasant memories Recall of significant life moments Feelings of wellness Assists with expressing emotions Good feelings Associate feelings and story with metaphor

Table 3.23: Comparison of diagnostic groups – Theme 11

Major Depressive Disorder	**Schizophrenia-spectrum**
Music revealing unconscious aspects of self Initiated musical ideas Ownership of music space Heightened awareness of specific aspects of music Recall of specific memories Recall of significant moment Use of metaphor to reflect on music's benefits Symbolic material	Initiated musical ideas Requested words of songs Heightened awareness of specific aspects of music Limited awareness of specific aspects of music Concrete associations of objects and people with personal story Recall of specific memories Feelings of wellness Inspiration and motivation

	Desire for music therapy sessions to continue Music assists with expression of emotions Reflects on music symbolically

3.13. Theme 12 – Resilience in courage

"*I feel free, even though it won't take, but I would like it to last. To feel free from the bondage that I'm having now, to, what can I say, not to fight, but gently to untie through therapy and stuff like that, not fighting, but taking it slowly*" (A28 1d).

Profoundly depressed, skeptical about the possibility of recovery, and wishing to escape from her stark reality Client A states this intention for therapy: "gently untie" (A28, 1d).
This theme captures the "untying" which took place for many clients. A different process for each client, but one which facilitated glimpses of resilience, courage, motivation and the possibility of change. This theme is expressed with reference to i) accepting circumstances and events, ii) change for the better, iii) strength and courage, iv) growing motivation and goal setting, v) persisting forward and vi) attributing personal virtues.

3.13.1. Accepting circumstance and events (VA102) (VR149, VR159, VR178, VR179, VR211)

Statements referring to acceptance were made against the backdrop of complex, difficult life circumstances. Forgiveness and forgetting are included in this sub - theme as representing steps towards acceptance. Examples from the data include:

With reference to her suicide attempt said "to accept what happened" (E24 6f), referring to difficult domestic circumstances which renders him "moody, anxious, heavy, viscous" uses an image to reflect on other qualities he needs to access " forgiveness and acceptance" (F20 2g, 2h), "accepting that I need help, the small steps I'm taking now is self-evaluation, starting to change the things I didn't do before e.g. being able to put myself first sometimes and being able to communicate my emotions to other people which I did not before" (I23 5k), spoke of the need to accept her circumstances (J24 6m), "what's past is past I can't bring them back" (J25 7p), "forget about the past which was very sore to my heart" (J26 8h), "when we accept there come tears of joy again" (J8 5i), of her HIV status: "not easy to accept my sickness" (J8 5j), "I accept myself" (J8 5m).

With reference to her difficult marital situation Client H spoke of her need to apologise to her husband for hurt she inflicted upon him. She articulated the expressed desire for his forgiveness (H22 4f-4r),

In the final session Client P selected the word 'content' in the symbol transformation technique. She said: "It represents acceptance, fullness, balanced and it makes you be in a space where the situation might not be good or the best that you expect it to be, but you are content" (P26 8g, 8i).

3.13.2. Change for the better (VA17, VA89, VA90,VA95, VA144) (VR15, VR27, VR52, VR84, VR90, VR158, VR208)

References to change in the data firstly apply to both active and music therapy techniques. The data will be cited with reference to the two umbrella approached of music therapy.

3.13.2.1. Reflections on change in Active Music Therapy

The vocal improvisation was extended into an impromptu songwriting. I started playing a chord sequence and client began narrating in spoken voice over the chord sequence I was playing: *"Once upon a time there was this lady called ……she was very depressed when she started music therapy, but when time passed by everything became clearer and clouds were like parting, going, moving in all directions,* I add voice humming a melody and she begins to clap a rhythm while she continues to narrate over the music, *"and she become everyday stronger, her mindset has changed totally, she sees the world in a different light, and it's a better feeling for her. She never felt like this before and everything become better and better every day" (Client A, A18, section of transcription: session 7).*

Statements about change experienced in active music making included references to stimulation, awakening, gain, feeling better and shifts experienced in musical expression. Examples from the data include: "enough of boring rooms", "*oo, genoeg gesit by die kamer* – oh, enough sitting in the room" (R3 1m, R4 1h), "I remember the first day and thinking how is it going to help me, ja I was so negative. But I said to myself let me give it a try. I woke up emotionally" (A11 7w).

Statements indicating a shift in feeling state after relaxation include: "*dit voel bietjie beter* – that feels a little better" (H2 1g), "was very tired. I'm refreshed now" (P15 3k), "*Beter. Dit voel beter* – Better – this feels

better" (S2 4d), reports feeling better after relaxation (S27d), "don't think like before" (J2 8f).
After drumming: "*ek was op my senuwees. Ek voel "n bietjie beter* – I was nervous. I feel a bit better" (T14 4k), experienced drumming as better than previous session (H6 2t), experiences a difference in the anxiety through drumming (H11 2i).

Other moments of change and insight include: at the end of an improvisation which was an extension of the song "Stronger than the pain" **(Audio Clip C, Track 23 – Stronger than the pain**), the client said in an exclamatory, definite manner "Ja, this is it" (A11 8m **– Audio clip D, Track 24 – This is it).** Other references include: "puts you in a different time frame (G8 4r) and "it puts you in a different space which is absolutely fun" (G84w), after a movement exercise said "Lekker. I gain something" (N12 1d).

3.13.2.2. Reflections on change through Receptive Music Therapy

Statements of change during verbal reflection, as part of Receptive Music Therapy techniques, refer to change in mindset, help, healing and recovery, and music shifting mood. Data examples include: " I feel better because of the song we played of being strong" (A24 6s), "music put me in a nice mood" (F26 8k), "sometimes maybe you are angry and you sing a song it can put us in place (P19 1c), "storm in my head is going" (R21 3f), *"musiek is "n ding waar jy kan wegbreek van alles en meer aan al daardie kretiewe dinge dink* – music is something where you can break away from everything and think creatively" (T23 5l), " feeling better due to mind change" (E22 4p), "no more crying". "mind closed now open, eyes closed, now can see", "I don't think now to commit suicide again" (J24 6c-6k), indicated that it was time to heal (G19, 1k, G24 6h), refers to the barrier slowly breaking, says that she is feeling better and working through problems" (I22 4c, 4f), indicated that she did not like change but stated that her being moved from a security ward to an open ward is a sign of getter better: "*Ek is besig om gesond te word* – I am busy getting better". (S26 8d, S25 7k).

3.13.3. Strength and courage (VA08, VA124) (VR05,VR77, VR86, VR95, VR96, VR100, VR101)

"Facing my emotions, but then I don't know, it's such a fear. I've got such a fear of doing so and I'm afraid of what's going to happen. But then it happened last night and I'm back to normal today. Face it, I've been bottling up again. Last night I was very down. That fight gave me the willpower to get up" (Client I MDD, I22: Session 4)

Active musical participation and music listening afforded clients' access to strong, courageous aspects of self. Data examples refer to the capacity to confront, discovering inner resources, expressions of resilience, empowerment, survival and strength.

The song, "You Raise Me Up", was incorporated in session 06 as the basis for a movement exercise. Clients were invited to listen to the lyrics and choreograph interpretive movement in response. It is worth making specific mention of this song as it elicited varied comments alluding to being strengthened such as: "ja, it's quite an emotional and strengthening song" (A12 6n), "music builds up" (F12 6j), "Feel hopeful, loved, it builds up, is strong" (F12 6j), "Sjoe, for me what raises me up is (daughter"s name), she raises me up to more than I can be" (I12 6g), "it made me very strong, yes I'm strong. I can face everything" (J12 6g), "I've found the strength in God to stand strong", "to stand and look the world in the eye", "look everyone in the eye" (R12 6f, 6g, 6h).

Others references to strength include: "getting stronger" (A18 7h), "forward I go, stronger, stronger, and I will win" (A18 8g), "my heart feels strong" (J18 8f), "songs make you strong" (T14 6g)"I have to be strong like the mamma fish" (A24 6ao), "the barrier makes me stronger" (I22 4p), need patience and strength to cope with difficulties (P23 5h), associates image drawn in session 6 with walking strong and says "I'm stronger than ever, and than everybody else" (R24 6e, 6f).

References to inner strength and inner resources include: "I am managing it with my internal strength" (P22 4i), "I have to use what I've got" (A24 7i).

Image 3.17a. (Client F - MDD, Session 4 – Empty)

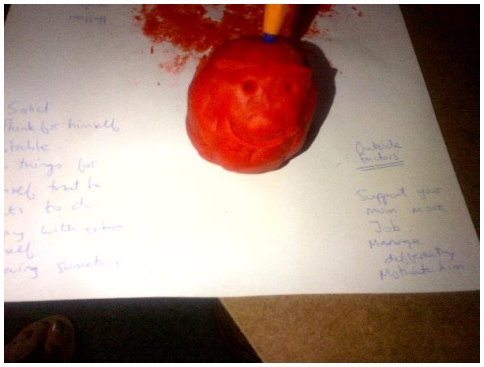

Image 3.17b. (Client F – MDD, Session 4 – Accessing inner resources)

Image 3.17a refers to an image Client F sculpted from clay:"A rectangular flat container. It's hollow, it's empty. There's nothing inside. A head, but nothing inside it. No realistic ideas, no thinking, it's hollow, it needs something inside to make it be something. To fill it". The client added to this description of the image that he felt useless (F 22 session 4).

Client F created a second image from the same piece of clay. This time "a happy face, solid, not empty (Image 3.17b). There's something inside. And he's happy. He can think. He's stable, he knows what he wants to do, he can think for himself and do things for himself which he wants to do, and of course he's happy. Happy with himself. Achieving. Ideas that are realised" (F22 session 4). This technique was a catalyst for Client F to begin to explore inner resources and consider alternate solutions for his circumstances.

References to resilience, courage and survival include: referring to an image (Image 3.18) she drew in the final session said: "I climb the ladder and here I'm a, here I'm a resident at my home, the door is no more rusted, I can get outside the house, and be resilient" (A26 8n).

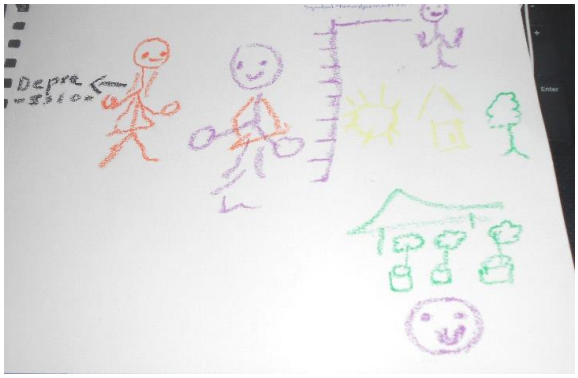

Image 3.18. (Client A -MDD , Session 8 – Towards resilience)

Other references include: “I’m not used to listening to my own voice”, “would mean a lot to find my own voice” (F21 3p, 3q), “all the things that have dragged me down will be my saving blocks” (I22ab) “as I drew the dark whirlwind of emotions, the cloud of smoke, I’m busy using it to build myself” (I23 5g) “courage looks like putting my foot down”, “there is still a cloud, there is sun coming from the cloud. I think that’s courage” (I24 6b, 6d), refers to her story text as giving her courage (S23 5h), “today I can survive without them” (J25 7i), “if you have love in your heart you will survive” and “I will learn myself better and see if I’ll survive” (P21 3g).

3.13.4. Growing motivation and goal setting

An important part of the intervention was to open ways for clients to translate sentiments evoked by music, images and reflections into practical application to everyday life wherever possible. Data examples refer to growing motivation, acknowledging the need for self-care and taking practical steps.
Referring to the prospect of a job opportunity said “I had that oomph, now I’m going for it” (A22 4aa), “I want to go to another level” saying that she wanted to complete a course indicating self- belief in reaching her goal (D22 4n, D23 5f, 5h), “That I’m learning how to motivate myself more. And I saw myself motivating other people”. She also referred to the need for self-care which she was addressing with her psychologist (E26 8d, 8e, E20 2t), referred to getting up from lying down to come to a session: “So I was a bit down this morning. I came to the session because it’s important for me to come here. I was lying down. I woke up and rushed here” (G23 5k), indicated determination to follow through on decisions and spoke of putting herself first: “putting myself first is such a big thing for me” (I22 4ac, I24 6e).

Along with experiences of strengthening and increasing levels of motivation came the opportunity to consider ways of translating this into practical application. Responses from the clients include: “first step is to know the skills” (A23 5ac), “write feelings down” and “look at promise ring” (E26 8j, 8l), referring to reconnecting with music “I know I can also do it with practice” (F24 6n), “I was thinking of giving clarinet lessons for young people” (F24 6r), taking a deep breath when battling to speak (I21 3p), to be a good mother (I26 8e), goal to attend Bible college (J21 3f), recognises that weight gain is something she can practically manage (P26 8j), “If I can get halfway with this in a day then I’ve already won because . It’s a drive to get up in the morning and go to work until five o clock” (G21 3r).

3.13.5. Persisting forward

For most clients accessing motivation and inner resourcefulness is extremely challenging as, in most cases, drive and affect are severely affected. In order for clients to journey towards change takes determination and persistence. The data indicate this element of struggle as expressed by some clients:
" Ja I had to go on no matter how tired I am", despite the emotions you are feeling whether you are happy or sad", "keep on going", "must persist", "going back means giving up", "I have to stand up and carry on", "the door is rusted but I have to push", "Even though I will fall, I will stand up and move on" (A8 2l, 2m, A112g, A21 3k, A23 5j, 5n, 5ap, A25 7f, A26 8t).

Reflecting on her story text said: "don"t give up" (E23 5v), "no quick fix", "need to pick myself up" (G21 3w, G25 7r), referring to the clay image of the barrier said: " break the barrier", "keep on breaking the barrier even if it"s 1mm at a time", "taking small steps towards", "I have to break the barrier piece by piece", "barrier is breaking" (I22 4s, 4t, I23 5j, 5p, I24 6g).

"The greatest challenge was not knowing whether I would make it or not. The pressures that came with work. I wanted to be a good wife and mother and the perfect me…Developing internal strength and endurance to balance all three. If you don't have patience and endurance you won't achieve" (P25 7g, 7i), "reflecting on an image she drew in session 6 said: "I'm just walking strong. I'm in this stuff now, which is still this rubbish, everything's dead, there's nothing here. Moving out. I've got my eyes there" (R24 6g), "*ek moet vashou, aanhou en glo* – I must hold on, go on and believe" (S11 7l).

3.13.6. Attributing personal virtues (VA52, VA80, VA82, (VR26, VR69, VR74, VR87, VR102, VR139, VR161, VR166, VR182, VR185, VR186,VR218)

During the course of the music therapy intervention clients discovered new insights or attributed virtues to the self which may not previously have been considered, or which were reawakened. Such insights or attributes include expectations of self, new experiences of self, specific self attributes, feelings of significance, self-belief and confidence.

3.13.6.1. Expectations of self

With reference to breaking the barrier of depression said: ""not expecting too much of myself", "so I can't expect to break all of the barrier in such a short time" and "I must give myself time" (I11 4h, 4i, 4j), referred to having high expectations of self (E24 6v).

3.13.6.2. New experiences of self

Data references include: "Other part of self revealed" and "never knew there is that person in me" (A23 5ae, 5ah, 5ar), "thinking about where I was and where I can be" (E26 8q), "I will learn myself better", "with you here I've learned there are spaces we can find ourselves in" (P21 3f, P26 8p), "*in touch met jou self* –in touch with yourself", to become more in touch with nature and self" (T20 2diii, T23 5k), "I'm a new person" (J25 7i).

3.13.6.3. Specific self attributes

Clients attributed personal virtues to self or described themselves in various ways. Examples from the data include: "I'm ***proud*** because I didn't play this before" (D8 5y), acknowledges that she is quiet but alright (O8 6j) "the white represents that I am still ***pure***" (E20 2f), "I'm ***beautiful"*** (J25 7i, J18 8b), described self as 2ci) ***relaxed***, 2ciii) ***dramatic***, 2civ) ***loving,*** 2cv) ***lively,*** 2cvi) ***sociable*** (S20 2c, S19 1f), describes self as ***happy*** and ***balanced*** and as ***confident, quiet, shy, sweet*** (P20 2k, P20 2d).

3.13.6.4. Feelings of significance and self confidence

Client F (MDD), in a music-centred visualisation, imagined himself playing solo in a band setting. In his reflection afterwards he said "I feel important in a way, like many of these people would wish they can do what I can do on stage, and listening to what I'm doing….Ja, I'd like to be a role model" (F24 6i, 6k). In session 7, recalling the incident where he was honoured by late President Mandela he said:*"And that day Nelson Mandela was there. He speeched and the band played for him. He came down the passageway with his people, lot of people, but the band stayed playing while he was walking, I was standing at the side of one wall and he comes in, but he was far away from me, about 20m, he walked there. I had my uniform on and I saluted him there already, and he come from out of his crowd of bodyguards, he comes to me, walks to me,*

20m or whatever, far, and he get my hand. That was a moment I will never forget, I just took my other hand and shake with hand too. It was a great moment. I mean for him, he was walking and talking with his people, and he saw me out of the corner of his eye, and he told his bodyguards stay here, and he walked to me there. And what did that do to you? *It was great. Afterwards I was actually crying, that happy… I worked many times with him, but I was always in the band. I just said thank you. Sjoe"* (Client F (MDD), F25). Recalling this memory helped the client connect with a part of himself that was worthy of being recognised. This was in direct contrast to his statement of self "Ja, I'm useless" in session 4.

Other statements reflecting self- belief and self -confidence include: "I can do it" (A11 4e), "*Ek is baie special* – I am very special", (H18 8e), "now I can be someone" (J11 7e), after the first instrumental improvisation Client T said: "*self satisfaksie, ek is die moeite werd, dis nie dat ek nutteloos is nie* – self-satisfaction, I am worth it, it is not that I am useless" and in session 8 said " *Ek beteken iets vir myself. Ek's nie 'n niks* – I mean something to myself, I am not a nothing" (T8 1q, T26 8m).

3.13.7. **Comparative findings – Theme 12** (Resilience in courage)

When comparing the respective music therapy techniques, Active Music Therapy was experienced as an emotional awakening, offering an alternate active experience and alleviating boredom. Both music therapy techniques elicited a shift in feeling states and experiences of inner strengthening. Receptive Music Therapy elicited responses linked to feeling states of motivation, contentment and acceptance. Altered self-perceptions, movement towards recovery and practical applications indicating desire to change were elicited through Receptive Music Therapy.

When comparing diagnostic groups, both groups referred to music therapy shifting feeling states, accessing inner strength, renewing motivation to persist, looking to the future and altering self-perception. Clients from both groups reported feeling better and experiencing feelings of self- significance. The SS-group indicated music alleviating boredom. References from SS-group also include statements about wanting to survive and the need to hold on. The MDD-group articulated feelings of hope, emotional awakening and increased motivation. References to specific steps towards recovery, intention to deal with pain, articulated future goals, desire to access inner voice and inner resources, as well as steps taken during the music therapy process were unique to the MDD-group.

Table 3.24: Comparison of music therapy techniques – Theme 12

Responses elicited by Active Music Therapy techniques	**Responses elicited by Receptive Music Therapy techniques**
Emotional awakening	Need for acceptance
Shift in feeling state	Intention to restore relationships
Alleviates boredom	Feeling of contentment
Different experience from daily routine	Creativity
Fun	Break away from everything
Movement and music making as strengthening	Shift from the despair of suicide
Elicited feelings of significance and self-belief	Towards recovery
	Strengthening
	Associated symbols with getting stronger
	Inner strength
	Intention to act
	Experienced imagery linked to resilience
	Accessing own metaphoric voice
	Reference to survival
	Increased motivation
	Realization that self -care is necessary
	From symbolic to concrete application
	From reflection to concrete application
	Intention to persist
	Motivation to move forward
	New experiences and perceptions of self
	Recall of memories affirming self-worth

Table 3.25: Comparison of diagnostic groups – Theme 12

Major Depressive Disorder	**Schizophrenia-spectrum**
Intention to deal with pain	Music alleviates boredom
Negative at beginning of therapy	Shift in feeling state
Awakened emotionally	Gaining from music

Indicated experience a difference through drumming	Break away and think creatively
Different space from daily routine	Shifts feeling states
Music as fun	Getting better
Strengthening	Feeling stronger
Shifts feeling states	Need for patience and strength
Feeling better	Accessing inner strength
Increased willpower to attend sessions	Inner courage
Feelings of hope	Wanting to survive
Uses metaphor associated with feeling stronger	Need for endurance
Accessing inner strength	Looking to the future
Uses metaphor to access inner resources	Holding on and believing
Associates imagery with need for resilience	Experienced self in new way
Desire to access inner voice	Self -affirming statements
Setting future goals	Feelings of significance
Identifying practical steps for the future	
Articulate the will to persist	
Realistic assessment of self	
Experiences self in new way	
Self- affirming statements	
Feelings of significance	

3.14. Theme 13 – Invigoration and liberation

This chapter began with the two themes ‘not to feel’ and ‘to do or not to do’ which reflected the difficulties clients experience with regard to feeling and expressing emotion as well as taking action and accessing inner drive. This theme contrasts these difficulties with the capacity to experience and express pleasure, joy, liberation and heightened energy levels. Each sub- theme is presented with reference to Active and Receptive Music Therapy respectively.

3.14.1. Experiencing music as pleasurable (VA20, VA84) (VR78, VR164)

This sub-theme will be discussed with reference to Active and Receptive Music Therapy respectively.

3.14.1.1. Experiencing pleasure through Active Music Therapy

There are numerous references in the data which indicate responses of pleasure with regard to active musical participation. The following examples provide a cross section of these responses: “eish, so beautiful” (J14 2g), experienced vocal improvisation as “beautiful” (I15 1h), after an improvisation: “it’s like background music, people eating, something like that. It’s nice” (F8 8i),”very nice. This sounds happy” (I11 3k), “wow, this is so nice. Brings it out in such a subtle, calm way” (I11 4k), described improvisation as a journey, sunshine (I11 8g), “very nice. Good music” (N8 3k), “music very nice” (N8 6k), Other references to music making being experienced as “nice” are (O62l, O12 7i, P4 1g, P6 2m, R11 3f). Other expressions of pleasure include:- experienced mirror image as wonderful (P14 2h), experienced improvisation as good (Q8 2o), “*dit was ‘n goeie ervaring gewees* – that was a good experience” (Q12 6h), “*goed gevoel* – felt good” (Q8 7z), “*ek is mal oor hierdie musiek* – I am mad about this music” (S16 1g), experienced mirror image as wonderful, restful (S14 2i), “*dit was baie lekker. Dit was baie mooi, dit was lekker* – That was very good, very nice. That was good” (S12 6h), “was very nice”, “*mooi liedjie opgemaak*- made up a nice song” (T8 5h, T8 7n).

3.14.1.2. Images and music listening linked to positive feelings

As has been illustrated during the course of this chapter, music listening elicited a range of images and emotional responses from clients. The examples from the data illustrate images and symbols which represents feelings of pleasure: “ superman logo, sun” (I24 6a), “sun, people grouped, smile” (I22 4l), “I saw the band, people around them happy” (F24 6e), Visual depicting heaven, children, nature, water (H24 6c), Text- rainbow after the rain” (P24 6c), Visual – nature scene, bird in flight” (R19 1c), “visualised ballerina dancing and an eagle” (R19 1e), Text- riding on horseback from sand to desert to green desert, strong” (R24 6c), metaphor of bird learning to fly for new beginning(T25 7k), Visual – sun with smiley face (T26 8d), in response to music listening: “ It felt nice”, “calming” (E19 1d, 1e), after visualizing himself playing in a band: “that was a good feeling” (F24 6h), “feel better to see nature” (L20 2f), reflected on sun as symbolic voice.

3.14.2. Expressions of joy (VA03, VA06,VA15, VA18, VA19, VA94) (VR20, VR 21, VR57, VR156, VR181)

Active and Receptive Music Therapy elicited different forms of expressions of joy. References from the data will be discussed according to the respective music therapy techniques.

3.14.2.1. Expressions of enjoyment and fun in Active Music Therapy

In some respects these data references resonate with the previous sub - theme of music being experienced as pleasurable. Here the data indicate more heightened responses of joy and enjoyment: "it puts you in a different space which is absolutely fun which I haven't had for a long time" (G8 4w, 4x), "that was so much fun" (I8 4m), described improvisation as fun, "it has rhythm" (L8 3m), "*dit was fun* – that was fun" (S12 1h). References to excitement and happiness include: "it was excitement, I was starting to enjoy the music" (G84s), experiences excitement (H11 2j), when learning that therapist brought the "Adele" song she wished to sing Client I (MDD) exclaimed "whooo" (i8 7a), " I feel ok, I feel happy" (E2 3g), experienced movement as happiness (E12 7n), "I wish to be happy" (D11 5g, H18 8d, 8h), "I'm happy", "after all this comes joy" (J8 1g, J15 2i, J8 5l), "Dit voel alright. Ek voel happy" (N4 1k).

Expressions of enjoyment in music making: "oh yeah" (A5 4t), "Ja. That was cool" (A8 5ai), expresses enjoyment of the blues (F8 1l), "I enjoy the music" (G15 3o), enjoyed playing the drum (H4 1f), "I always tell them in the ward I enjoy the music" (J8 3r), "it feel good. It feels good.", "I enjoy it, I enjoy it" (K2 1d, K12 1i), "it was fantastic. You can dance with your feet and with the movement" (L14 3k), of the relaxation: "*baie geniet* – enjoyed it very much" (T12 2i).

Expressions of humour: said that his side stretches in the relaxation looked like a ballerina (Q2 5d) and shared a quip about the possibility of falling asleep during the relaxation" (R2 1a).

3.14.2.2. Reflections indicating joy in Receptive Music Therapy

"Yes I can be very joyful" (A20 2q), acknowledged the need for joy (G25 7v), "associates joyful space with her daughter" (I20 2c), "don't know what feeling, but good, happy" (E21 3i), "just to be myself and be happy, laugh more" (F21 3g), visual represents love and happiness" (E24 6c), "happy emotions contained in deep breath" (I21 3m – see Image 1), "steps to the reality of being happy and free" (I25 7fi – see Image 7), "I want

to see myself smiling" (J22 4e), depicts self in happier space (J24 6j), associates feeling happy with the image (N21 3f), "*ek voel happy* – I feel happy" (N20 2g), image of flower representative of being happy (O25 7h).

3.14.3. Liberation (VA33, VA74, VA83, VA136, VA141) (VR29, VR30, VR44, VR191)

As with the previous sub-themes, the sub-theme of liberation will be presented with reference to Active and Receptive Music Therapy respectively.

3.14.3.1. Experiences of liberation through Active Music Therapy

The data indicate that experiences of liberation were afforded in active music making through play, stress release, emotional expression, and spontaneity.

After a drumming improvisation: "Ja, I felt liberated, feel that I can do anything that I.." (A4 1m, 1n), after an instrumental improvisation said "it felt so spontaneous" (A8 2k) and during session 3 spontaneously began to sing nursery rhymes which developed into a joint improvisation between client and therapist. In the verbal reflection afterwards, referring to the need for play said: "Than being an adult with problems and stuff and then when you're a kid, everything is fine" (A5 3y), engaged freely in a movement mirror image exercise after which she said "*Jissie, dit was lekker* – gee that was nice" and then reflected on having done acrobatic dancing as a child of 12 (H14 3f), exclaimed "wow" after a drumming improvisation (D11 4d), after a spontaneously composed song said "Don't know where that came from"(G18 8w).

In session 3, Client T, without any directive from the therapist, spontaneously created a story during an instrumental improvisation, about a stick figure, his mother and a snake. It was not the content that was of importance in the moment, but the shared musical enjoyment that spontaneously emerged (T8 3c).

Audio clip E (Track 25 – Spontaneous story) illustrates this. The client begins to narrate the story using different instruments, such as the tambourine and the woodblock to sound the story. The therapist supports the client through accompanying the story on the piano whilst asking occasional questions and reflecting some of the story line through singing.

Further references include: acknowledged experiencing stress release (F11 1m) and in response to the mirror image in session 3 gestured with his hands of experiencing the movement coming from within him (F14 3o), " I experience that I become, I take a deep breath, feel release" (J11 3j) and at the conclusion of a drumming improvisation: "let it go" (R11 3h), in response to movement said: "*Ek het myself uitgeleef , ek het dieselfde gevoel as wat die woorde se* – I expressed myself. I had the same feelings as what the words said" (T 12 6h).

3.14.3.2. Reflections on freedom in Receptive Music Therapy

The theme of being free was particularly salient to Clients A, F, I, R and S. Numerous references to freedom, free and space were made by these five clients.

"Makes me calm. I think of freedom. And the feeling of freedom" (F21 3d, 3f), "*Ek wil spontaan wees* – I want to be spontaneous" (F25 7n), referred to a time prior to her illness where "I felt like I needed to be free", which is in direct contrast to her current experience rendering her afraid of freedom (A21 3ak), referred to steps towards being free (I25 7fi), worked with the themes of freedom, space and love (R19 1f), "free, go on the wind and be free" (R19 1f), associated the symbol of an eagle with freedom (R19 1h), described herself as being free on her farm (R19 1i), the wind symbolised freedom, peace and love (R23 5f), drew an image entitled "As free as a bird with my family" (S21 3d – see Image 19), story text focused a young girl wanting to be freed from her circumstances. (S23 5b).

Image 3.19. (Client S – SS, Session 3 - Freedom)

3.14.4. Energising to life (VA91) (VR88, VR89, VR105, VR111, VR140)

This sub-theme is expressed through experiences of heightened energy levels within music making, as well as references from Receptive Music Therapy techniques which indicate an awareness of being alive, the possibility of growth, and references to feeling energised.

13.4.4.1. Energised through Active Music Therapy

"I feel alive" (D12 1j), "very, very energetic" (D14 3l), in response to therapist's comment about the increase in energy in the music: "Ja, I did more, ja" (F3 5j), after dancing spontaneously and energetically the client stated: "that's why I said I'm coming to music therapy today" (J14 5h), acknowledged increase in musical energy (J3 6k), "Nice energy from the music…I feel good... Do something ja"(N8 5v), "it energises me (dancing)" (P13 8f), described session as "energy, living, life" (R14 4i), "*baie op en wakker* – very lively" (T14 4j).

3.14.4.2. Reflections on being energised through Receptive Music Therapy

Some clients, in the midst of trying to cope with the challenges of mental illness and, in some cases, those who were hospitalised due to suicide attempts, displayed an increasing awareness of being alive, with renewed prospects of growth and living:

With reference to Image 9 "This is just to flow, easy go, I am not very happy but I can draw strength from other things that are there , so ja I'm still alive (gestures with large body movements) I want to think now deeply about this one. I'm thinking of other patients, um they look happy, and they don't complain so it gives me another picture of saying..they see life, it's maybe they don't realise much but they look very happy and all that, even though things are tough, other people they go on" (A24 6ae).
Other references include: "That depression is not a side effect of dying. That's how I used to feel" (E22 4n), "I'm ok now. I must not think about tomorrow. I don't know what tomorrow is having for me. I don't want to think about tomorrow. As long as I got life" (J25 7n), referred to wanting "grow up like a tree", which became the basis for a song composed over the course of a number of sessions (O20 2h, 2j, O21 3e), associated images from sessions with growth and life (P21 3d, P26 8e), shares a strong connection with the outdoors said, based her story text on the theme "Wind" and refers to finding her source of life in nature:

"The wind is always playing. Always playing on everything and everything's playing in the wind. You see how birds can let go. In nature there's life. If you love nature you can live" (R23 g), describes herself as: "*Dat ek 'n vrolike mens is, ek is lewenslus, wat wil lewe, wat krag het vir die lewe* – I am a jovial person, I want to live, strength for living" (S19 1f), drew an image of the sun in the final session representing living with increased energy (T26 8b, 8e).

3.14.5. **Comparative findings – Theme 13** (Invigoration and liberation)

Common to both active and music therapy techniques is that feelings of joy, happiness, freedom and life were elicited. Active Music Therapy elicited the expression of self, experiences of fun and pleasure, the opportunity for spontaneous creative expression, stress release through music making and experiences of liberation and humour. Receptive Music Therapy elicited imagery associated with joy, happiness and freedom. Clients articulated the desire for happiness, freedom and growth through Receptive Music Therapy techniques.

When comparing the two diagnostic groups, both groups experienced music as pleasurable and energising, improvisation as fun and associated imagery with positive feelings, The SS-group associated imagery with feelings such as happiness, growth and freedom and there is reference to a desire for living. The MDD-group articulated the desire for happiness, freedom and spontaneity and imagery was associated with future desires. Furthermore, the MDD-group expressed feelings of enjoyment, shifting perspectives and experiences of stress release and liberation.

Table 3.26: Comparing music therapy techniques – Theme 13

Responses elicited by Active Music Therapy techniques	**Responses elicited by Receptive Music Therapy techniques**
Pleasure	Imagery associated with positive feelings
Expression of self	Imagery associated with joy
Improvisations experienced as fun	Feelings of happiness
Feelings of joy	Desire for happiness
Expressions of enjoyment for specific aspects of music making	References to freedom
	Associated symbol and metaphor with freedom

Humour	Desire for freedom
Experiences of liberation	References to life
Offers experiences of spontaneity	Gratitude for life
Spontaneous story creating	Desire for growth
Stress release	
Self -expression through movement	
Increased energy	
Feeling alive	

Theme 3.27: Comparison of diagnostic groups – Theme 13

Major Depressive Disorder	**Schizophrenia-spectrum**
Music bringing out expression subtly	
Experienced music as pleasurable	Music as pleasurable
Imagery associated with positive feelings	Imagery associated with positive feelings
Imagery associated with future desires	Imagery associated with freedom
Music as fun	Improvisation as fun
Experienced music with enjoyment	Feelings of happiness
Feeling happy	References to humour
Enjoyment about music preference	Associates symbol with happiness
Enjoyment with reference to different aspects of music making	Spontaneously created a story to music
	Space for self -expression
Desire for happiness	Freedom
Liberation	Associated metaphor and symbol with freedom
Being spontaneous	Music as energising
Stress release	Movement as energising
Desire for freedom	Awareness of life
Desire for spontaneity	Personal growth
Feeling alive	Associates symbols with growth
Increased energy	Desire for living with increased energy
Awareness of being alive	Desire to live
Shifting perspective when compared with others	

3.15. Post therapy semi-structured in-depth interview: Summary of emerging themes

As described in chapter 2, a post therapy interview was conducted with 15 participants. Fourteen participants had attended all 8 sessions and one participant attended 7 sessions. The interviews were conducted by the therapist-researcher and subsequently analysed independently by a registrar in psychiatry. Below is a list of tables (Tables 3.28 – 3.39) that provide a summary of the 12 emerging themes detailed through sub-themes and core experiences that express the essence of each theme. The themes serve as corroborative evidence supporting the findings of the music therapy process analysis. The three sets of themes will be considered in chapter 5.

Table 3.28. Theme 1 - Post therapy interview

Theme 1: Praising the impact of music		
Sub-themes	**Core experiences that expressed the themes the best**	**Quotes that express core experiences**
Praises for music therapy	Wonderful experience	"It's [participating in music therapy] a wonderful experience, really."
	Likes everything of music therapy	"No, [I would not change anything], I like everything."
Music therapy has made an unforgettable impact	Makes an impact	"I will not forget this [music therapy] …because it made an impact on me."
	Will not forget music therapy	"I will not forget this [music therapy] …because it made an impact on me."
Music is an essence of being	Without music people are nothing	"Without music I am nothing, one cannot go on without music."
	Music is the heart and soul of human beings	"Music it's the heart and the soul of human beings, from long

		time ago it kept them going."
Music therapy is unique	Music therapy is unique	"that [playing the drums] was unique, and I have never done it before."
	Something different	"It [playing on the drums] was something different."

Table 3.29. Theme 2 – Post therapy interview

Theme 2: Gaining perspective		
Sub-themes	**Core experiences that expressed the themes the best**	**Quotes that express core experiences**
Changing perspective	Changes mind-set	The patient refers to a specific Zulu song that reminded her of nature: "How God loves us so much then, and when I look the nature."
	Music therapy gives insight	"It [the music therapy sessions] made me aware, it gave me insight, so when I went out here I thought about what I did and the lessons that I learned."
Gaining perspective	Helps to see the light	"It [music therapy] help me because it takes away bad feeling, it did, and then um it helped me to see light."
	Open up doors	"And that [the music therapy] opened up other doors again for me exploring how I can get rid of those ill feelings again."
Renewed awareness	Realise God loves us	The patient refers to a specific

of God and Higher power		Zulu song that reminded her of nature: "How God loves us so much then, and when I look the nature."
	Makes patient feel close to God	"I experience a lot that they [playing the different instruments] put me next to God."
Gaining perspective on the past and its connections to the desired future	Connects the past, current, future	The patient drew circles during the drawing exercise and it became symbolic for him, to explain, the past, current and future: "One where I was, where I'm now and where I want to be…Yes, it makes a connection."
	Helps to picture where patient is and where patient wants to be	It brought insight for the patient: "My emotions, to where I am and where I can be."

Table 3.30. Theme 3 – Post therapy interview

Theme 3: Taken up within own experience		
Sub-themes	**Core experiences that expressed the themes the best**	**Quotes that express core experiences**
Put out of mind at the time	Ignore things that worry	"When I am hurt, I must sing, I must calm down, it helps me to ignore some things that are worrying me then."
	Takes patient out of the room	"When we did obviously, the music and what I could relate it

		to and being able to draw, it was always soothing…and it definitely took me out of this room and."
Focusing the mind	Occupies the mind	"Your mind is nowhere other than in the noise that the drum is making, so it's kind of getting you occupied."
	Focusses the mind	[The relaxation and breathing exercises] "Focus my mind."
Heightened self-awareness	Realises own resilience	"Finding out [through music therapy], that I have the part that is strong, so I must like keep on being resilient."
	Teach to be in touch with yourself and emotions	[Through the music therapy] "I have learned that a person should be more in touch with yourself and your emotions."
Welcomed "New experience"	Learn new things	[By talking to the music therapist] "You learn new things."
	Feel feelings in a different way	"I touched some feelings that I didn't want to touch but yet by touching them I felt the feelings in a different way than it was portrayed to me in the past."

Table 3.31. Theme 4 – Post therapy interview

Theme 4: Creatively inspired and energised for the future		
Sub-themes	**Core experiences that expressed the themes the best**	**Quotes that express core experiences**
Inspiration to go forward	Music therapy encourages	"And if there's another song that encourages you, it's time to sing, reflect and do something with it."
	Music therapy gives motivation	"I think it's [the music therapy] motivation."
Music therapy is energizing	Emotionally alive	The patient felt that the music therapy was filling and therapeutic and said the following about it: "things for example like making you emotionally alive."
	Music therapy is exciting	"I think the drumming was very exciting because I had done it just a little and then I started doing it and then I also saw the fact that you can change the rhythm as you go and then it was very nice."
Unleashing creativity	Brings out creativity	"We could play any type of music and adapt, and change rhythm and that brought out my creativity."
	Movement exercises wake inner child	"It [moving exercises] sort of woke the inner child inside of me

		that I could still be friendly."

Table 3.32. Theme 5 – Post therapy interview

Theme 5: Coming to joy and peace		
Sub-themes	**Core experiences that expressed the themes the best**	**Quotes that express core experiences**
Yearning for achievement and joy	Movement exercises not enjoyable	"The music therapy make my heart happy."
	Movement exercises frustrating	"I must say that it [movement exercise – 'mirror-image] was a bit frustrating sometimes, and wish it would end now."
Enjoyment and laughter	Happy heart	"The mirror-image [movement exercises] wasn't really so enjoyable."
	Makes patient laugh	"I'm better, I'm healed, I'm everything and I can laugh today."
Peaceful comforting	Soothing	"When we did the music and what I could relate it to and being able to draw, it was always soothing."
	Comforting	"It [music therapy] was mind blowing and were very comforting."
Feeling better	Feel good inside	During a relaxation exercise: "I feel good inside."
	Brings good things	"It [music therapy] emptied feelings, it emptied some things

		in me, and also it brings good things, so it helps me because it takes away bad feeling."

Table 3.33. Theme 6 – Post therapy interview

Theme 6: Liberation – to do and from frustration		
Sub-themes	**Core experiences that expressed the themes the best**	**Quotes that express core experiences**
Rid of anger and irritation	Express frustrations	"Geez, amazing, it [improvisation] was enjoyable to take out frustration out on the drums."
	Causes irritation to be less	"It [music therapy] made me relaxed, I am not so irritated after it [music therapy."
Liberating	Allow self to be free	"Um playing the instruments, allowing yourself to be free, just playing the way I want to play, yes."
	Realise there is life outside of Hospital	Through listening to music in the therapy, he realised**,** "That there is a life outside of Weskoppies."

Table 3.34. Theme 7 – Post therapy interview

Theme 7: Upbuilding and filling		
Sub-themes	**Core experiences that expressed the themes the best**	**Quotes that express core experiences**
Upbuilding and filling	Music can heal	"Um yes my condition is a chronic one, but I'll always keep in mind that music can heal people."
	Music therapy is therapeutic	[Music therapy] is "Um, therapeutic um, filling."
Improving yourself	Gives confidence in self	When patient took the lead, and developed certain moves to the music, "I got confidence in myself."
	Music therapy makes for personal growth	"I think it [music therapy making him talk about things, he wouldn't talk to anybody about] makes you grow in a way."

Table 3.35. Theme 8 – Post therapy interview

Theme 8: Closer and improved interaction		
Sub-themes	**Core experiences that expressed the themes the best**	**Quotes that express core experiences**
Getting closer	Music therapy generates togetherness	The patient emphasised:" …and [making music] together."
	Interact	"…the relaxation gives you space to really interact in the other things that we did."
Improved interaction	To communicate better with other	The patient felt that the impact

	people	the music therapy had on his life was as follows: "My breathing got better and communicating with my fellow people also improved."
	Taught to be around people more	"It [music therapy] taught me a lot of things, to be around people more."

Table 3.36. Theme 9 – Post therapy interview

Theme 9: Opening up and emotionally dealing with old wounds		
Sub-themes	**Core experiences that expressed the themes the best**	**Quotes that express core experiences**
Take back to the past	Reminds about memories	"…and you [music therapist through music therapy] give me that chance to remind me my old things, and my now things, it's very important."
	Discovering places that haven't gone in a long time	"Discovering places [traumatic memories] that I haven't gone in a very long time."
Opening of and dealing with old wounds	Wanted feelings came in and unwanted feelings went out	"It really helped to get rid of wrong feelings, you know when you're cross, you feel better, it helped to get rid of feelings and wanted, and wanted in…and wanted out."
	Opened wounds	"A lot of the times I was a bit sad

		and upset when I left here but for a reason [music therapy] opened up some wounds and made me, made me look at life a bit differently."

Table 3.37. Theme 10 – Post therapy interview

Theme 10: Grappling with and to change		
Sub-themes	**Core experiences that expressed the themes the best**	**Quotes that express core experiences**
Realise life is continually changing	Life not always static	"…where [through drawing exercises] you [music therapist] showed me that life is not always balanced, but a person can be balanced, but life is not always static."
	Life never comes twice	"Because life comes once, yes, life never comes twice."
Grappling to change	I will never change	"I am who I am, and I will never change."
	I am who I am	"I am who I am, and I will never change."

Table 3.38. Theme 11 – Post therapy interview

Theme 11: Strengthening more than anticipated		
Sub-themes	**Core experiences that expressed the themes the best**	**Quotes that express core experiences**
Strengthening more than anticipated	Source of strength	"...yes, it [music therapy] was mind blowing and those [music listening exercises] were very comforting, yes, a source of strength."
	Stronger than pain	Describing the emergent feelings in music therapy as "I'll be strong, strong, stronger than the pain."

Table 3.39. Theme 12 – Post therapy interview

Theme 12: Unease in and before therapy		
Sub-themes	**Core experiences that expressed the themes the best**	**Quotes that express core experiences**
Impaired state before music therapy	Thought of himself to be weak before music therapy	**"…**Um, I never knew that there's another part of me that's strong, I always thought I'm weak, I'm weak, I'm weak."
	Low before music therapy	When a song of being raised up was sung, he expressed symbolically "yes, because I was

		low and I felt that there are pillars in my life."
Disturbing and uneasing	Improvisation is chaotic	"...and then the sound that it [rain stick during improvisation] made, it sounded kind of chaotic, but it was really something to think about."
	Improvisation doesn't make sense	"It [Improvisation] wasn't making sense to me at all."
Betrayal	People might betray you	"...because they [other people] might betray you."
	People disturb life with things	During listening exercises the patient realised she was happy in the past until: "and then people come and disturb your life with their things."

Chapter 4: Findings: Musical Affordances

The themes expressed in Chapter 3 provided the context for this chapter in that the clients' experience of receptive and Active Music Therapy respectively is heard through verbal responses.

This chapter presents the themes that emerged during the analysis of the active music making component of the music therapy intervention. This component included structured music-centred exercises and improvised music making in the form of instrumental improvisation, drumming, movement and singing. Each theme is concluded with comparative findings which describe the similarities and differences between the diagnostic groups with regard to participation and response within active music making.

4.1. Introduction

The themes in this chapter are expressed through the analysis of clients' musical participation as described by the therapist-researcher. Musical qualities described include tone pitch, timbre, dynamics, phrasing, melody, harmony, meter, rhythm and instrumentation. Descriptions refer to the clients' individual musical participation as well as within the joint musical interaction of client and therapist. The 131 video recordings are available to support the descriptions of the musical affordances. See Appendix I for an example of the in-depth descriptions of the 131 music therapy sessions which formed the basis of the data collection for this study.

Included in this chapter are audio and video excerpts that serve to illustrate the expressed themes and support references to the written data.[2] The audio and video excerpts are available on the CD provided (see Appendix VIII).

As with chapter 3 where there are numerous references within a specific theme or sub-theme, examples from a cross section of clients will be cited. When describing specific examples from the data the client and diagnostic group will be indicated as MDD- (Major Depressive Disorder: Clients A-J) and SS- (Schizophrenia-spectrum: Clients K-T). First level codes are indicated as e.g. C12 3a (Client C, column 12, Session 3, first code). Second level codes are prefixed with VA, VR or AM. These indicate verbal responses to Active Music

[2] Video footage has been edited so as to protect the identity of the clients.

Therapy (VA) and Receptive Music Therapy (VR) and active music making (AM) respectively

Table 4.1 – Themes – musical affordances

Summary of themes and sub-themes: Musical affordances		
Themes	**Subthemes**	**Reference to data**
Reciprocal responding	**Extent of engagement**	*Looks down whilst playing (S8 7c)* *When therapist modulates and increases energy she looks away and sings quietly (O8 4k)* *Lose focus the longer a musical activity continued (Q14 3f)* *The client comes back into focus when the therapist reflects on the piano an action on the xylophone (glissando) played by the client.(H8 7h-7j)*
	Extent of responding	*Looks up in response to musical changes (L14 2h, N85k, P3 1i)* *The response of the client elicited spontaneous call and response within the music (N3 3e)* *Responds to increasing energy of the improvisation (H3 5c)*
	Musical and relational awareness	*Seemed in own space through averted gaze or body posture (I14 5d, I12 5b, L14 2f, I12 5f)* *Client unaware of music intervention and continues with perseverative music (E3 8j)* *Aware of changes introduced by therapist (H3 3h)*
Explicit use of symbols through music	**Explicit use of symbols through music**	*Uses music to reflect internal fight (I11 4e)* *Uses music instruments to interpret the story (T8 3e)* *Reflects fear and loneliness through the music (I11 5e)*
Regularity	**Rhythmic stability**	*Leads counting of pulse in steady manner (T8 5d)*

		Rhythm more stable than previous session (Q3 3 a) *Plays accented beat and rhythm becomes steadier (O3 2g)*
	Flow	*Joint music lacks continuity (I8 5f)* *Difficulty sustaining flow or coordination (Q3 3e)* *Within the flow of the music client changes instruments (F8 3f)*
	Amplifications of musical tension/accent	*Anticipates and plays accented beat (S8 7n)* *Plays accented beat of Tango (N7 6f)* *Counted aloud with therapist, rhythm more steady (S3 3c)*
Disturbing and difficulty	**Limited**	*Music has blunted quality within limited dynamic range (O8 3f)* *Limited melodic material (E17 1f)* *Movements within limited range (G12 3b)*
	Incongruence between musical and non-musical	*Energy when dancing contrasts to blunted affect non musically, difference between presenting mood state and quality of the music (F4 4h)*
	Difficulty	*Struggled to physically hold the drum (N7 5e)* *Difficulty remembering and mirroring multimodal rhythm (G6 2e)* *Experiences sung dialogue as difficult (H11 4c)*
	Rigidity and perseveration in musical material	*Sings phrase repeatedly in blunted manner (P11 4c)* *Repeats movement and requires prompting to change (Q14 3d)* *Continues with rigid rhythm when therapist changes meter (P3 2i)*
Turning Points	**Retreating to familiarity**	*Plays characteristic fast quaver rhythm (J3 6a)* *Reverts to original rhythm after short time (Q3 5d)*
	Shift in musical quality	*Begins to extend range and vary melodic material (P5 3e)*

		Broadens repertoire of movements in subsequent turns (Q14 3c) *Shift in music, energy and focus from earlier sessions (S8 8q)*
	Weeping	*Weeps during movement exercise (H12 6e)* *Became emotional and quiet as we played the drum (R10 2e)*
Energy bursting and lacking	**Qualities of energy**	*Plays conga with bursts of energy (M5 4e)* *Movement was animated and energetic (J12 1b).*
	Extent of energy	*Energy low and facial expression blunted (P3 3a)* *Energy levels higher at conclusion of improvisation (H11 2g)* *Played high energy, fast rhythm on djembe (R3 4a)*
Bodily synchrony	**Bodily synchrony**	*Tremor severe as client begins movement (H14 2a)* *Aspects of stiffness in body (A14 4g)* *Moved naturally and expressively (j12 6c, J12 7b)*
Intensified emotional expression	**Emotional intensity expressed in musical dynamics**	*Client's playing is quiet, runs fingers across wind chimes (E11 7g)* *Joint singing has flow and gentle quality (T17 1e)* *Plays strongly and intensely (F8 7l)*
	Musical sentiment	*Sings song with sensitivity (P16 1f)* *Playing loud, forceful (F3 3n)* *End on poignant note (J12 6f)*
Exploring new territory	**Spontaneous music initiative**	*Moves to new instrument and introduces change in the music (F8 4g)* *Stood, danced in spontaneous uninhibited manner (T12 1g)* *Initiates tempo and dynamics changes (A11 4d)*
	Interactive music thrill	*Client's musical initiative set up playful vocal interaction (I5 3c)*

		Joint music strong and playful (H3 4y) *Joint movement interaction relaxed and playful (R14 4h)*
	Musical exploration	*Explored music space playing various instruments (H8 5n, N8 7b, O8 5d, P8 6c)* *Explores different ways of playing the drum (F4 1g)* *Improvise melody where therapist plays long phrases on guitar (Q8 8c)*
	Confidence	*Dismissive of own music (F8 7z)* *Uses voice in uninhibited manner for the first time (H3 6j)* *Starts improvised section with confidence (I16 2f)*
	Musical sharing	*Interactive turn taking in response to client's initiative (O3 2n)* *Alternate leadership and vary movement (P14 2f)* *Mutually responded to contrasts and musical ideas (T8 8g)*
	Recalling of process	*The more we play the rhythms the more she is able to recall them (P7 6g)* *Remembered vocal work from previous session (Q15 2a)* *Managed three rhythms without reminders at the end (M7 7d)*
	Creative elaboration of musical qualities	*Sings short phrases and gestures to the therapist to sing (Pf 3a)* *Extends improvisation when Th tries to end (D3 5j)* *Extends melody and sings long phrase (A15 7g)*
Resolution or arrival	**Holding**	*Holds rhythm when therapist introduces changes (I4 1h)*

		Holds her own musically even when hesitant (O3 6e) *Holds pulse while therapist improvises (H3 5i)*
	Clarity	*Develops more defined rhythm (D85j)* *Sings clearly during known section (G16 4h)* *Not fragmented exploration of music space but music as coherent whole (T8 5f)*
	Resolution	*Completes musical phrases alone (D17 4e)* *Silence when music is finished (F14 2i)* *Ends improvisation with strong, sustained note (P8 4q)*

4.2. Theme 1 – Reciprocal responding

At the core of the music therapy process in general, but in particular during the Active Music Therapy component, was the interaction, musically and interpersonally, between client and therapist. The interaction developed and was expressed in various ways. The theme, reciprocal responding, focuses on three aspects of the client/therapist interaction: a) extent of engagement, b) extent of responding and c) musical and relational awareness.

4.2.1. Extent of engagement

The data indicate that clients' level of engagement was experienced in different ways and through a range of responses. These responses included reluctance to initiate own musical material (AM266), delayed response when invited into musical participation by therapist (AM16), resistance (AM104) including resistance to using own voice in music making (F53a, F15 5a), or choosing not to sing (J8 2l, J8 3n, L16 3c), averting gaze when invited to change an aspect of the music or choosing not to actively participate musically e.g. When therapist modulates and increases energy she looks away and sings quietly (O8 4k).

The data furthermore highlight variation in quality of musical engagement, for example, less engaged: averted gaze and disengaged (S3 4h), looks down whilst playing (S8 7c), stares ahead while playing (S87c, indifference about musical participation and going through the motions (AM82): plays within pulse but 'automatic' quality to music (L8 1h), going through the motions, rather than exploring the space (H8 7e). Some clients tended to lose focus within musical participation, which seemed to be linked to the duration of

a musical process, i.e., the client would lose focus the longer a musical activity continued (Q14 3f). Concentration also seemed to play a role with clients struggling to focus, in the here and now, on the musical task at hand.

Whilst limited response, lack of initiative and loss of focus describe some ways in which clients engaged in music making, the data also reveal that clients demonstrated the capacity for presence, engagement and focus during musical interaction (AM 23; AM27). Increased engagement was seen through body language, movement towards the therapist, sustained focus in musical interaction, higher energy, taking responsibility within the music space, increased concentration levels, more focused engagement during structured musical interaction or when prompted by the therapist in the moment: pitch not accurate but level of engagement has energy and variation (G16 4l), engaged body language G15 3g), facial expression and body language suggest engagement with the improvisation theme (J11 3i).

Audio clip 1 (Track 1 – extent of engagement)

Audio clip 1 is an example of fluctuating levels of engagement. In an instrumental improvisation, Client H (MDD) was invited to play a selection of percussion instruments whilst the therapist played the piano. The audio excerpt illustrates how the client moves between moments where she is engaged in the music, (reflected in the joint music created by client and therapist), and moments where she is less engaged (e.g. stops playing the drum mid phrase, begins playing the xylophone in a fragmented manner unrelated to the preceding music). When the client begins playing the xylophone the therapist adjusts her music to the client's through a key modulation and change of dynamics on the piano. The client comes back into focus when the therapist reflects on the piano an action on the xylophone (glissando) played by the client. The client looks up at the therapist and laughs, responds by initiating another glissando which the therapist plays simultaneously with her. The client laughs again when this is reciprocated and engages more fully in the joint musical interaction.

4.2.2. Extent of responding

For many of the clients, as indicated above, responsiveness was limited. This, in turn, impacted the duration and quality of musical engagement. This does not imply that clients are non-responsive within music making, but rather that interventions are necessary to offer moments through which response can be elicited, heightened and sustained. The data indicate that the client's musical responses were facilitated through

various means such as:

a) learning musical material (AM 34) which entailed learning new songs, specific rhythms, movements and different instruments: learns new rhythm with ease (E8 3u, N7 6b), manages to play the three rhythms (P3 8f)

b) mirroring musical and movement ideas (AM 37, AM 248 and AM299). Included in the process were drumming and movement mirror exercises which develop the client's capacity to watch, listen and focus and then repeat what they have seen or heard by mirroring it back to the therapist precisely. Built into this technique is a reciprocal component where the client is required to create rhythmic patterns and movements which the therapist, in turn mirrors back to the client. Mirroring invites the client into interactive musicing which facilitates both interpersonal and musical responding: e.g. mirrored therapist's movements (O14 2c), mirrors rhythm precisely (E6 2b, G6 2a, I6 2a), mirrors precisely when therapist repeats and reinforces rhythm (G6 2f), mirrors new idea precisely (I6 2f).

c) prompting the client through musical interventions and verbal cues (AM 105, AM 252, AM307). Prompting, in this instance, does not imply that the client required assistance, but rather that the client required an invitation to respond which facilitated varied musical experiences: changing instruments (E8 1h, G8 1m, L8 3e, N8 2g), varying aspects within the music (E3 4w, E3 8o, Q8 4j), starting or ending an improvisation (J14 3a, N3 8k, Q6 2k), motivating a client (F8 8z, T3 2b), recalling music from previous sessions (N7 6c, P7 6e, Q8 6f, R8, 3k), setting boundaries and anchoring clients (S7 6b, Q8 7n,)
Response varied in content and expression (AM 49) ranging from evoked responses (H11 3l, H11 5f), H11 6d), to spontaneous responses e.g. responding to the therapist's music by extending a musical phrase (E17 1e), spontaneously counting out loud in response to a music intervention (H3 1g), the response of the client elicited spontaneous call and response within the music (N3 3e), a description of a client's improvised music being responsive and creative (F3 8c) and response being immediate (E17 1a, F12 1c, H12 1b).

Non- musical responses to musical ideas and interactions included, e.g. stands when she hears the music (P12, 1a), smiles in recognition of known song (G8 1h) and looks up in response to musical changes (L14 2h, N85k, P3 1i)

Responses in the music included musical responses to specific actions by the therapist e.g. slows down briefly in response to an intervention (M8, 8f), recognises known song and sings loudly (H15 2b), offers different movement in response to directive approach from therapist (M14 2i), responds to strongly pulsed intervention (M3 1i), responds to accelerando (P4 1e), responds to increasing energy of the improvisation (H3 5c) and responds to slower tempo (P3 3h).

Responses were also in relation to the therapist's musical or verbal instructions e.g. understands and plays shorter turns (O4 1f), following rhythms in response to therapist explanation. Then there were responses which indicated a shift in the client's musical participation– breathed more during movement (T14 4l), more flexible use of voice in response to interventions (P5 3g) and musical response more natural and less evoked (H3 4l).

The data indicate the following three modes of musical responding:

a) copying (AM13, AM223) , comprised three primary features. Firstly this referred to the clients' tendency to copy the therapist's musical material in a rote or evoked manner. When this occurred it seemed as if some clients experienced difficulty accessing inner resources rendering them limited or unable to articulate an independent musical voice within the musical interaction (F5 3k, N5 3c, Q3 5f, M15 1f). Secondly clients displayed a tendency to copy the therapist's music even when invited to play something different from the therapist. (S3 1i, N7 5c, M15 1f). Thirdly copying also refers to one client' in particular' who responded to pre -recorded music in the sessions which he recognised from his days of being a professional musician. He attempted to copy what he had heard by playing melody lines and chords on the piano or the guitar. (F8 5r, F8 6b) This spontaneous response suggests the client's venturing back to his own music and venturing out by sounding an aspect of the music alone.

b) following musical cues (AM 124) is distinct from copying in that the client might respond to a change initiated by the therapist, follow the therapist's suggestion or direction, but not necessarily copy the therapist's music precisely (P14 2e, S8 1j). The data also indicates that 'following' refers to occasions where, when both client and therapist were playing independent musical material, the client would immediately follow the therapist's musical changes instead of sustaining his or her independent musical voice. (J6 2j, L14 3g, N12 6d).

c) adapting/adjusting to changes (AM03). This form of response is linked to an increasing flexibility and engagement within interactive music making. The data indicate that change/adjustments responses in the clients' music includes the following: a) changes occurred in response to interventions or changes initiated by the therapist e.g. adjusts music as therapist introduces contrasts (G4 2i), adjusts music, plays stronger beats (G3 5e). AM03 includes many such examples (C15 1p, F3 1s, H8 2d, G8 7h), b) clients adjust one aspect of playing but not necessarily another e.g. adjusts to different meters but quality of playing does not vary. Herein were examples of change/adjustment responses which were juxtaposed with musical qualities such as fragmentation, lethargy and blunted musical qualities – e.g. adjusts to slower tempo but music becomes fragmented (O8 2m), adjusts to meter changes in lethargic manner (P3 4c). Other examples include (E7 4k, E8 7ae, O3 4m, P3 4c), c) changes which occurred more naturally within the musical interaction without a specific intervention or change initiated by the therapist. The change could equally be initiated by the client, to which the therapist would respond – e.g. adapted one of the movements which therapist followed (M12 6e), other such examples include (H3 4c, O3 1f, P3 2l,).

d) increased musical flexibility (AM77). The data indicate firstly that, in the case of some clients, musical flexibility increases over time (N3 4f, T3 4i, Q8 6p)), in others cases, clients develop greater flexibility with regard to specific aspects of e.g. rhythm, voice, during song writing, with regard to tempo, during improvisations and in movements (P8 2k, P16 2g, P18 8f, Q8 6o, T12 7f). The data also suggests increasing flexibility within the musical interaction between client and therapist (Q8 6p, F8 8ae).

4.2.3. Musical and relational awareness

The third sub-theme describes the extent of musical and relational awareness. This is presented, with reference to the data, in terms of i) awareness of the here and now, ii) awareness of the therapist's music, iii) awareness of the music and iv) awareness of self.

4.2.3.1 Awareness of the here and now (AM59, AM261)

The data refer to instances where clients experience difficulty orientating to the here and now – e.g. seemed in own space through averted gaze or body posture (I14 5d, I12 5b, L14 2f, I12 5f), require orientation into exercise (L14 2c), and experience fluctuating levels of awareness (L8 1o, L6 2j). This seemed to apply more to the clients on the schizophrenia-spectrum.

4.2.3.2. Awareness of therapist's music (AM61, AM60, AM 222, AM59, AM261)

The clients' awareness of the therapist's music seemed to fall along a continuum. On the one hand clients displayed limited or no awareness of the therapist's music – e.g. client unaware of music intervention and continues with perseverative music (E3 8j), does not seem to be aware of song introduced by therapist (L8 3j), unaware of changes introduced by therapist (L3 3d), unaware of numerous interventions by therapist (P8 7i) (AM61) Audio Clip (Track 2).

Audio clip 2 (Track 2 – Limited awareness)

This audio clip illustrates Client P (SS) playing the djembe drum. The client plays in a rigid, perseverative manner playing the same rhythmic pattern repeatedly. She looks down whilst playing the drum. The therapist matches the clients playing, occasionally varying the music by adding extra beats. The therapist changes the meter to a ¾ rhythm. Initially the client is unaware of this. She continues looking down, playing her original rhythm. The therapist plays the new meter with exaggerated body language, the client looks up and stops. When invited to continue playing she reverts to her original rhythm. Whilst the client showed fleeting awareness of the therapist's presence when her drumming was more visual and exaggerated she did not display awareness of the music per se.

On the other hand, though, the data indicate that clients displayed heightened awareness of the therapist's music – e.g. adjusts to the therapists quieter singing at the end (C15 1p), aware of changes introduced by therapist (H3 3h), seems aware of therapist following her music (H8 8k), aware of pauses and changes introduced P8 6h), stops playing when therapist introduces pause (Q8 1d), watched therapist's drum during joint improvisation (T7 2d), sings bass line under therapist's melody (T16 3d).

Audio clip 3 (Track 3 – Awareness of therapist's music)

This audio excerpt draws from work with the Client P (SS), referred to in Track 2 which was taken from session 1. This particular client typically played instruments and sang in a rigid manner, she had a strong, forte singing voice but seldom used her voice or instruments in a nuanced or flexible manner. Once engaged in a musical exercise the client seemed to have difficulty focusing on anything outside of what she was doing, often resulting in perseverative music and limited awareness of and contact with the therapist. Track3 is an excerpt from Client P's sixth session. Client and therapist were engaged in a vocal and instrumental improvisation, both singing, therapist on piano and Client P playing the tambourine. Upon close listening to

the improvisation, a) the client's tambourine playing is perseverative and has a mechanical quality, the client's voice is loud, at times has a forced quality, she does not always sing on pitch, although she does offer independent musical material in the form of an alto harmony. Towards the end of the clip the therapist slows down and pauses, extending the phrase – the client responds by waiting in her music, seemingly very aware of the ritardando in the music – she looks up at the therapist, lowers the dynamic of her voice and softens her voice quality singing a note that leads the music into a new key (from minor to major). The joint singing becomes more spacious, mutual and warm, and the client seems more aware, with a listening stance, of the therapist's music.

4.2.3.3 Awareness of the music

Apart from clients displaying varying levels of awareness of the therapist/therapist's music within the musical interaction, the data reveal the clients' awareness of the music itself. This was evident in the following ways:

Recognition: (AM46). Examples from the data include: recognises melody and joins in (C15 1k), recognises and sings known song (F15 2e), recognises and plays different rhythms distinctly (E8 6r), recognises Afrikaans folksong played by therapist, smiles in recognition of known song (G8 1h) and remembered two of the instruments from previous session (Q6 2a). The recognition of musical material included familiar music from client's own experience as well as music which grew in familiarity over time during the music therapy process. What the data suggest is that the recognition is a precursor to some form of musical engagement as indicated by these examples.

The music itself: (AM 57, AM 279, AM 278, AM 259, AM 220). The data firstly suggest varied extent of awareness of specific musical elements such as tempo, pulse, pitch (AM330) and rhythm. E.g. Across both client groups there were occasions in active music making during which clients demonstrated both awareness and lack of awareness of the pulse- e.g. adjusts to pulse and plays in steady manner (I8 4h), plays within pulse, with moments of fragmentation (J3, 4i), holds pulse while therapist plays solo (M7 3b), played solo section within pulse (N7 5b) **or** – seems not to hear or feel pulse when playing different rhythm (G7 3d), does not seem to feel pulse (G3 5a), seems unaware of pulse when her turn to solo (I7 1c), does not seem to hear pulse when therapist introduced slow meter. (Q8 2i).

Other examples of musical awareness include – indicates preference for softer music (D4 1l), awareness of chords (F15 1a), identified guitar chord (F15 1b), aware of changes in the music (M3 2g, O3 5d, O8 8g, S8 6j), seems aware of tempo change (S8 6j), changes rhythm when I introduce voice (Q8 3f), adjusts voice to pitch (I8 7e)

Further examples of musical awareness refer to the movement component of the music therapy process: - as music starts client moves (A12 6c), interprets lyrics with own movement A12 (6h), movements become stronger as music intensifies (E12, 6g), worked with the energy of the music (H12 4e), anticipates the music (I12 6e), mirrors rhythm and feel of the music (P14 2c), interpretive movement as soon as words began (T8 6c).

The above examples suggest that awareness of the music is either followed or accompanied by some form of musical action or response on the part of the client. When there is limited to no awareness of the music, the client's musical participation has a different quality which can be characterised by perseverative music which, unless prompted to change, seldom leads to active musical change or action. This, however does not imply non-participation or non-response on the part of the client.

4.2.3.4. Awareness of self

Finally, the data suggest that clients demonstrate varying levels of awareness with regard to self, body, space and the therapist. Examples from the data include: seeming discomfort with movement (F12, 1a), aware of own movement (F14 2c), able to wait (D14, 2i), indication that she is self-conscious about others watching her (H12, 4f) and can feel body responding to music (G12 3j), seemed in own space moving naturally to the music (I12 5b), body turned away from therapist (I 12 5f), requires orientation into exercise (L14 2c) and begins playing while therapist is talking (L11 3a).

This theme suggests that engagement, awareness and response are experienced across a spectrum, encompassing the full extent from limited to heightened.

4.2.4. **Comparative findings – Theme 1** (Reciprocal responding)

The data indicate that clients from both diagnostic groups participated in music making with varying levels of engagement, awareness and responsiveness which ranged from limited to heightened. Just as clients representing both diagnostic groups presented with limited levels of engagement, awareness and responsiveness, particularly during the earlier music therapy sessions, so there were clients from both diagnostic groups who were able to sustain musical engagement indicating increased levels of awareness resulting in increased responsiveness and musical flexibility. Clients from both diagnostic groups experienced difficulty with concentration and focus at times. Clients from the SS-group seemed to experience more difficulty focusing in the 'here and now', often looking down, averting gaze or staring ahead during music making. Clients from the MDD-group seemed more self-conscious of their ability to make music, whilst clients in the SS-group in general seemed less self- aware. Clients from the SS-group required more prompting and orientation to the music and seemed to experience greater difficulty playing independent musical material compared with clients from the MDD-group.

4.3. Theme 2 – Explicit use of symbols through music (AM01, AM05, AM112)

As presented in chapter 3, music listening processes elicited, inter alia, symbolic material, personal associations and emotional responses. The Active Music Therapy component extended these experiences offering clients an opportunity to further explore symbols and emotional material through music improvisation and songwriting. The following examples from the data illustrate how the clients used music to reflect such symbolic material: e.g. varies the music to reflect breaking barrier piece by piece (I11 4d), uses music to reflect internal fight (I11 4e), plays drums, imagining self on horseback (R11 6d), reflects fear and loneliness through the music (I11 5e), selects tambourine for 'strong woman' theme (P11 7d), uses music instruments to interpret the story(T8 3e) and improvised based on three circles – 'look forward', 'look up' and 'spread your wings and fly'. Clients also associated certain aspects of the music with personal or abstract associations – e.g. associated bells with Christmas (I8 3c) and music associated with a thriller.

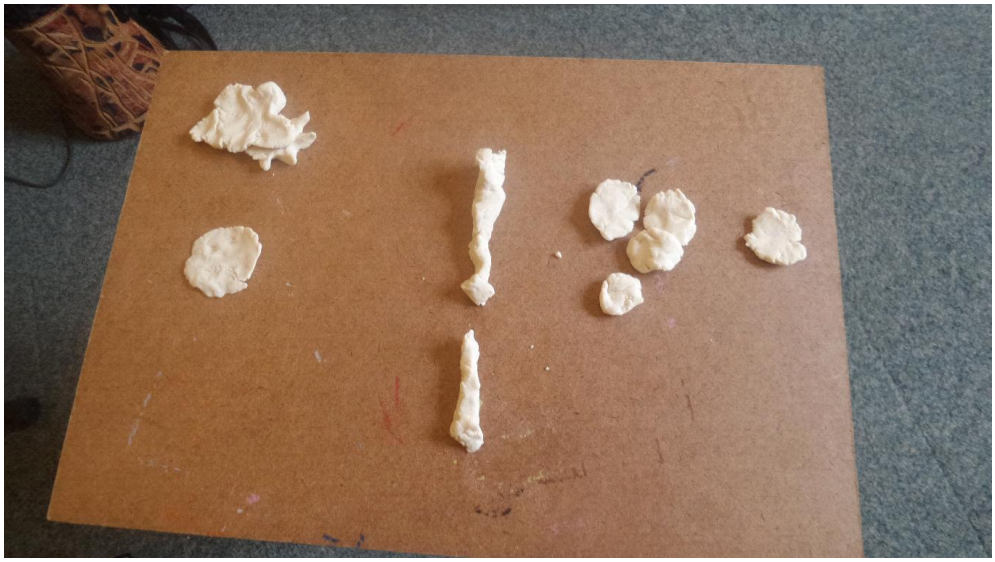

Image 4.1: The barrier

Client I (MDD) created this clay image (Image 4.1) to represent how she experiences her current circumstances. The line down the centre represents a barrier, which the client refers to as her depression, separating her from her family. She depicts herself as isolated on the left hand side under a dark cloud. After some discussion I suggested she listen to a second piece of music and rework the clay (only if she so chose) to represent a desired or envisaged change.

Image 4.2: Barrier transformed

As the client reworked the clay she used the barrier line and the dark cloud to create the sun (depicted on top left) Image 4.2). She reworked the image to represent desired closeness to family and a happier state. After some verbal reflection we represented this through musical improvisation. The client chose the title "decimal breaker the barrier". This title juxtaposed the desire to break the barrier of depression with a considered understanding that it would be a process which would take time.

Audio clip 4 (Track 4 – Decimal breaking the barrier)

This audio clip illustrates how the client uses the music to give further expression to the clay image process. The client leads the music playing the conga drum while I support her on the piano. As the clients plays the conga drum she develops the musical narrative, occasionally providing verbal interpretation of her music:

> *Having a fight with myself in my mind…….(When tempo increases)…I win, The positive side wins….there goes another piece…not expecting too much of myself (Client I, session 4)*

Track 4 is an example of how music, and in particular, free improvisation, extends the client's experience of symbolic material. The client musically represents a) breaking the barrier, b) her own internal struggle and c) her hope for a change in her circumstances.

The data illustrate how music, itself a symbolic medium, offers a sonic landscape through which to explore and further extend metaphor and reflect emotional expression. The client is free to direct the music and is free to appropriate the music any way that serves the specific experience. In this way active music making acts as a projective screen, relating to and performing clients' personal narratives and processes.

4.3.1. Comparative findings – Theme 2 (Explicit use of symbols through music)

Clients from both diagnostic groups reflected symbolic and metaphoric material through active music making. Clients from MDD-group, in general, worked with and developed symbolic material through clinical improvisation and songwriting across the music therapy process in a reflective manner, whereas clients from SS-group, with a few exceptions, worked with symbolic material more 'in the moment' and from moment to moment, without necessarily a sense of development and continuity across the 8-session process. It is noteworthy that within the SS-group some clients engaged with the symbolic use of music making in more abstract, intuitive ways, whereas others engaged with symbolic material through improvisation or songwriting at a more concrete level.

4.4. Theme 3 – Regularity

The third theme relates directly to aspects of the client's music making. The term regularity refers to the potential that exists within music for experiences of steadiness, regulation and flow, even within the presence of instability and fragmentation. Regularity will be discussed with reference to rhythmic stability, flow and amplifications of musical tension/accent.

4.4.1. Rhythmic stability (AM 273, AM40, AM114, AM270, AM271, AM 287)

The data suggest that all clients in the study played in a steady rhythm or kept a steady pulse at some stage during the music therapy sessions – maintained steady pulse (A8 3m), holds the pulse while therapist uses body percussion (D3 4s), leads counting of pulse in steady manner (T8 5d), steadies rhythm when hesitates (D3 2i), starts with strong, steady rhythm (E3 4s), plays steady rhythm which becomes fragmented at times (G8 3b), plays steady, independent rhythm (J3 1b).

The data also indicate that clients demonstrate the capacity to adjust rhythmic playing towards stability – examples include: plays steadier beat but music has fragmented quality (G8 1f), plays accented beat and rhythm becomes steadier (O3 2g), rhythm more stable than previous session (Q3 3 a), counted rhythm on conga more stable when she stands (S3 4c) and lifting hands stabilised rhythm (T4 4h).
Other references from the data refer to rhythm being laid back (F8 8d) and stable – playing more stable but difficulty regulating tempo (H8 1j), solo section rhythm more stable than previous sessions (j7 4e). Lastly, the data refer to music that is organised – adjusts music and plays with more structure (G3 3i), music becomes more organised (M8 4k), rhythm on xylophone more structured.

4.4.2 Flow

For most clients in the study, regularity within music making was often juxtaposed with music that was irregular or fragmented. Musical flow was present in music making through moments of regularity, as was the interruption of musical flow through irregular or difficulty experienced within musical expression. The data highlight three aspects pertaining to musical flow:

4.4.2.1. Difficulty structuring (AM 94, AM 179, AM33)

Within the musical structure and support provided by the therapist, some clients seemed to experience difficulty sustaining continuity within the music, especially in terms of structuring and defining the music: Examples from the data include: music fragmented and lacks definition (G8 1b), begins playing tambourine in undefined manner (S8, 1d), on black notes music lacks clarity (M8 2q), moves hurriedly and in unstructured manner between instruments (R8 5e), rhythm lacks structure, not always clearly defined (s6, se), joint music lacks continuity (I8 5f), varied the music but lacks structure (L8 2b), not able to structure the music due to limited focus (M8 2k) and plays xylophone in explorative, unstructured manner (08 5a). . These examples are neither an indication of low levels of engagement nor perseverative playing, but rather expressions of irregularity. There was still movement within the musical interaction.

Audio clip 5 (Track 5 – Difficulty structuring)

An audio example of this is taken from Client R's 5th session. Client R (SS) has selected instruments (xylophone, wind chimes, conga drum and tambourine) for an improvisation. She is invited to begin the improvisation. What is heard in the audio example is Client R finding difficulty settling into and structuring her own music. She moves from one instrument to the next, commenting "I'm stupid with music". Whilst this belief about her own musical ability may have had some bearing, this was session 5 and Client R's music, in general, was congruent with how she presented non-musically which was flighty, fast and restless. What the clip demonstrates is the therapist holding and working with the musical and verbal restlessness of the client. The therapist holds a simple chord structure on the piano which accommodates the lack of structure and irregularity in the client's music. Towards the end of the audio clip the client sustains her playing on the tambourine and xylophone. Whilst the client's playing reflects a restless quality, there is also increased regularity, movement and direction within the music.

4.4.2.2. Interrupted flow (AM 64, AM 68, AM 90, AM 130, AM 196, AM 212, AM214, AM 276, AM 277, AM281, AM282)

The data suggest various factors which interrupt musical flow. The two prominent factors emerging from the data are **irregularity** and **fragmentation**. These factors occurred across both diagnostic groups and with most clients. Examples from the data include: varies to irregular rhythm (E11 8n), starts rhythm which has irregular sections (G8 2b), rhythm irregular at times but musical presence is strong (J8 3g), music on

xylophone irregular quality (N8 5b), slows down or plays irregular rhythms when he varies rhythms (Q3 3d), rhythm on shaker irregular and difficult to match (s8 2b), rhythm fragmented and irregular phrasing (A6 2l), plays steady rhythm which becomes fragmented at times (G8 3b), music fragmented during solo section I7 1d), changes instruments and music fragmented (M8 2l), adjusts to slower tempo but music becomes fragmented (O8 2m) plays pulse with therapist but own rhythm fragmented (T7, 5h), tremor severe as client begins movement (H14, 2a). These were but a few of many examples. The data additionally reveals the following factors which interrupt musical flow:

a) **confusion**: becomes confused playing new meter at faster tempo initiated by therapist (Q3 3h), confused with song just used in session (Q15 1b)

b) **disorientation**: sings goodbye at inappropriate time (N8 5l), seems disorientated but aware of accented beat introduced by the therapist (T3, 2c), presented as more disorientated during this session (N8 5q), sat staring, blinking eyes, interrupted therapist (T12 1c)

c) **lack of co-ordination**: steady but clumsy rhythm due to tremor (H8 1b), movements not coordinated (Q12 1d), difficulty sustaining flow or coordination (Q3 3e), voice and rhythm uncoordinated but he uses initiative (Q8 5o), stops when therapist plays something different (Q3 1c)

d) **intermittent:** varies rhythm intermittently (G8 1o), music intermittently fragmented to which therapist adjusts (S11 5f), played for short while and changed instrument (G8 3c), stops playing (Q3 1c), not always joint musical flow-client stops to think (F4 1h), focused intermittently when therapist introduced contrasts in the music (O8 7j)

e) **disorganisation:** playing is disorganised during solo section (M7 3c, playing disorganised and gets faster (M16 3h), drumming steady but became disorganised (N8 5o) playing on Conga disorganised (M16 3c).

Audio clip 6 (Track 6 – Interrupting flow Client Q)

This audio clip is taken from Client Q's (SS) third session. Both client and therapist are playing the djembe drums. The clip illustrates how, within the musical interaction there are moments of hesitancy and irregularity, where the flow of the music is halted for short periods of time. The therapist, however keeps the music moving by providing a pulse, which is adjusted each time the client plays an irregular beat or stops mid phrase. As the clip ends, the therapist had increased the tempo and the client began playing in a more synchronous manner with the therapist.

Client Q's music was characterised by hesitancy, fragmentation and disorganization throughout the eight sessions. He was reliant on the therapist's direction and musical structuring for experiences of continuity.

4.4.2.3. Towards flow (AM 52, AM178, AM 213, AM 214, AM 235)

The data also indicate instances in which increased musical flow was experienced and sustained. The data Illustrate this in the following ways:

4.4.2.3.1. Sustains (AM52, AM213)

Clients demonstrated the capacity to sustain aspects of musical participation. Examples from the data with reference to both diagnostic groups include: sustains musical flow during hesitancy (A3 4u), sustains drum/clap, on/off beat section (G12 5j), sustains musical flow during hesitancy (A3 4u), sustains vocal flow with faster tempo (D17 4f) sustained piano playing in final section (H8 5l), sustains rhythm when therapist stops playing (Q3 4i), sustains steady rhythm when playing instruments simultaneously (R8 4d), sustains rhythm while therapist matches and holds he pulse (T3, 6c).

4.4.2.3.2. Expressions of flow (AM, 178, AM 213)

The data provide numerous examples of flow in active musical expression. This was evident in both diagnostic groups and in the case of most clients – flow in joint music (A5 3o), increased flow (A8 3t), joint flow from the start (E4 1b), within the flow of the music client changes instruments (F8 3f), musical flow in transition to new instrument (F8 4l), did not hesitate or stop during improvisation (H8 2g), kept the flow in the musical dialogue (R17 1e), turn taking with flow and client played independent musical material (N3, 8g), joins in within the flow of the music (P3 5f), energy and flow in drum dialogue (T4 4b). References to flow within movement include: moved with more flow (A14, 4f), concludes mirror image with larger, flowing movement (H14 2d), movement has more flow (L14 3h).

4.4.2.3.3. Flow in joint music making

The majority of references in the data that refer to flow occur within the context of joint music making between client and therapist. Examples from the data include: flow in joint music (A8 1t, A3 3i, A5 3o, F3 1m,

F3 5g, O3 6f), joint flow from the start (E4 1b), continuity in joint playing (F4 1e), interactive music has more flow and energy (H15 2j), jointly sustained musical flow (I6 2i), joint singing has flow (N15 2c), greeting song is interactive and has flow (O11 5j), joint music synchronised (F11 1i), two musicians playing together (F3 2n), joint interaction had flow (P14 3d), joint singing has flow and gentle quality (T17 1e), joint vocal improvisation had flow(T16 3c).

Audio clip 7 (Track 7 – Flow in joint singing)

This audio clip is an example of a vocal improvisation with Client T (SS). Client T, diagnosed with schizophrenia, presented throughout therapy as anxious and disorganised, with low energy and blunted affect. These qualities were often evident in his music. In session 4 the client requested the theme song from the film "Love Story" which the client and therapist sing together. The audio clip starts at the end of the song as the therapist initiates an improvised vocal section. Demonstrated in the music on the clip is the musical flow between client and therapist in the call and response section of the vocal improvisation and the client's sensitivity to changes in the music introduced by the therapist. As the vocal improvisation develops the client sustains a strong bass pattern, over which the therapist improvises a melody. In this improvisation the client assumes an organising role within the musical interaction which facilitates the resultant flow between client and therapist.

4.4.3. Amplifications of musical tension/accent (AM02, AM14, AM304)

As discussed previously in this theme, many factors contribute to irregularity in musical interaction. In contrast, the data also indicate mechanisms which contribute to musical regularity. These include accents, anticipation and verbally sounding rhythm: accents pulse (A3 4i), accents first beat (E8 3v), accents first beat of bar strongly (M8 4l), plays accented beat of Tango (N7 6f), plays accented beat and rhythm becomes steadier (O3 2g), jointly create anticipation at the end (E11 4u), anticipates stopping (Q3 2h), anticipates and plays accented beat (S8 7n), responds to intervention by counting and playing(H3 1g), manages rhythms when verbally sounding rhythmic pattern(M7 6c), more engaged when counting rhythm aloud (O7 4e), counted aloud with therapist, rhythm more steady (S3 3c), counts new meter and holds pulse (s7 5d), leads counting of pulse in steady manner (T7 5d).

Video clip 1 (Accenting and steadying)

This video track is taken from session 02, Client O. Client and therapist are engaged in a djembe drum

improvisation. The client's drumming is intermittently steady juxtaposed with irregular playing. The therapist first introduces accented beats at the original tempo during which the client continues to drum in a somewhat irregular manner. The therapist slows down the tempo and changes the meter, strongly accenting the first beat of each bar. The client's playing begins to steady once she also begins playing the accented beat, which is evident +- 30 seconds into the clip. It would seem that once the client embodies the accented beat and begins playing it herself that her drumming becomes more regular, as is demonstrated at the end of the clip.

This theme, thus, highlights the role that active music participation can play in providing experiences of regularity and flow within the presence of intrapersonal, interpersonal and musical challenges which clients experience.

4.4.4. **Comparative findings – Theme 3** (Regularity)

Whilst from both diagnostic groups there were clients a) able to hold and play a regular beat and b) those whose playing was fragmented and less organised, Clients from MDD-group, in general could sustain a steady beat independently and for longer periods of time, whereas clients from the SS-group displayed difficulty structuring and sustaining regularity or continuity within music making. Clients from the SS-group were more readily confused, disorientated and played with less co-ordination and more disorganization than clients in the MDD-group. The data indicate that clients from both diagnostic groups, however demonstrate the capacity to sustain moments of flow in music making, especially in joint music making. Clients from both diagnostic groups appropriated the use of, or responded to musical tension through response to interventions introduced or prompted by the therapist to assist in shifting music from irregular to regular musical expression.

4.5. Theme 4 – Disturbing and difficulty

This theme captures aspects of music making which clients seemed to experience as difficult or which reflect aspects of disturbance. This will be discussed with reference to four sub-themes: i) limited, ii) incongruence between musical and non-musical, iii) difficulty and iv) rigidity and perseveration in musical material.

4.5.1. Limited (AM 139, AM176, AM247, AM254, AM268, AM97, AM202, AM246, AM127)

The first aspect of this theme deals with the varied manner in which clients' musical participation seemed limited with regard to use of body, participation within the music and accessing musical ideas. The data refers to the following:

4.5.1.1. Limited body language and space

Whilst the terms 'small', 'quiet', 'sits still' are not synonymous with the term 'limited', these examples from the data are based on the quality of participation within music making and the manner in which clients' expressions were observed and described by the therapist-researcher: Examples from the data indicating limited use of body and space include: - sits still when music starts playing (L12 1a), sat still even when prompted to lead the movement (O14, 2b), did not move during second turn (O 14 2e), small body movements (B12 1d), sat forward, clicked fingers when music started (N12 1a), uses limited space (E12 7g), moved in small area (O12 7d).

4.5.1.2. Limited in the music

The data indicate various examples of musical expression described as limited: limited interaction in joint playing (E7 4h), joint playing is limited and perseverative (O8 2r), joint playing within limited dynamic and expressive range (J8 1b), plays within limited range (O8 2p), music has blunted quality within limited dynamic range (O8 3f), limited melodic material (E17 1f), limited range melodically, music has blunted quality within limited dynamic range (O8 3f) (P15 1d), plays within limited expressive range (E11 1i, E3 2f, E11 2e,), expressive range limited (Q15 1f), joint music reflects client's low energy and limited range (S8 3b), limited repertoire of movement (F14 2e), movements within limited range (G12 3b), did not dance much (P13 8b).

4.5.1.3. Limited in accessing musical ideas

Within the music therapy intervention, emphasis was regularly placed on inviting clients to contribute musical ideas across the spectrum of components. For some clients this came more spontaneously and naturally, whereas for others this seemed to be an area in which they experienced difficulty. Examples from

the data include: runs out of ideas (D12 1g), becomes increasingly reliant on therapist's ideas (H12 1e), could not access ideas as mirror image progressed (H15 2g), difficulty accessing ideas for improvisation (N14 3g), under resourced when her turn (D6 2l), cannot access ideas for a song S16 1f), 'stuckness' with new ideas (S6 2f).

These examples from the data indicate the tendency of clients to remain within the safer confines of personal and musical expression, rather than venture beyond. This did not apply to all clients, but did apply to clients from both diagnostic groups. As with all individuals, some are quieter, less confident and less extrovert than others. Taking this into consideration, these examples, however, seem to illustrate a sense of 'stuckness' within a limited range of musical expression, body language or use of the space. The clients to whom this seemed to apply presented with blunted affect and low energy throughout the music therapy intervention. This may indicate a link between negative symptoms and limited musical expression. With such clients specific interventions are necessary to offer a broader experience of self within the context of musical interaction.

Audio clip 8 (Track 8 - Limited expressive range)

The context for this audio clip is that client E, in session 05, had written a story as part of a Receptive Music Therapy technique. The verbal reflection afterwards led to a discussion during which the client articulated her need for social support. Part of the conversation focused on the fact that within supportive relationships there is room to grow, extend and make mistakes. This was translated into a music improvisation in which the therapist played a musically supportive role by providing the pulse in 4/4 time. The client was invited to play anything she wished and experiment with extending her musical boundaries within the supportive musical structure provided by the therapist.

The audio clip demonstrates how a) the client begins playing within a limited dynamic and tempo range, b) when invited to play something different she has difficulty accessing new or contrasting musical ideas (heard in the pause on audio, and seen on her facial expression on video) and c) has difficulty extending her musical range when invited to. Client E does increase the tempo and, to a lesser degree the dynamic level of her music. She subsequently plays in a more contrasting manner in response to the therapist's musical initiative. When invited to contrast this with softer playing towards the end of the clip minimal variation in the music is evident. (It is to be noted that the recording is amplified due to a) the small room in which the therapy took place and b) the use of djembe drums).

Client E's musical participation reflected her non-musical presentation during the music therapy intervention. She was very depressed, presenting with low mood, energy and motivation. These features were present in her music and may well have contributed to her tendency to remain within the safe confines of limited musical expression.

4.5.2. Incongruence between the musical and the non-musical (AM 88, AM149)

Audio clip 8 demonstrates an example of the congruence between a client's musical and non-musical presentation. In this case the music reflected the difficulties associated with the diagnosis of MDD.

This section presents something contrasting from the data. These few examples illustrate responses within the music which reflect an incongruence between, for example, mood state, energy levels, verbal content and musical expression: - discrepancy between affect and musical energy (F12 5g), energy while dancing different from non- musical presentation (M8 5d), energy when dancing contrasts to blunted affect non musically, difference between presenting mood state and quality of the music (F4 4h), difference between energy of client and energy of music, energy juxtaposed with robotic response (S10 4c), observed disparity between low energy/flat affect and music which has energy and definition (F3 1u). These instances refer to responses which indicate heightened energy and affect in musical expression in direct contrast to non - musical presentation of the client. Whilst this demonstrates music's capacity to facilitate shifts in mood and energy state, what is noteworthy in these examples is the split between the musical and non- musical responses. For example, Client S, in session 01 dances, with energy, to the music of La Bamba, whilst her facial expression in direct contrast indicates blunted emotion and low energy. As soon as the music was switched off and she was asked how she experienced this, she replied in a blunted manner stating "dit was fun" (S12 1g).

Audio Clip 9 (Track 9 – Incongruence)

Another example of incongruence between the musical and nonmusical is from session 6 with Client I (same client as Track 4). Verbal reflection followed a Receptive Music Therapy technique during which the client spoke in a strong, resolute manner:

> *Courage looks like putting my foot down, I don't know how else to explain it. What I see is being strong, putting my foot down, looking forward to the sunshine. There is still a cloud, there is sun coming from the cloud, I think that's courage. Actually putting my foot down, saying I want to, having the courage to say today I'm getting up and doing this, and as I'm doing that more sunshine*

comes through - deciding now I want to do this, and actually doing it and trying my best at it (Client I, session 6)

The verbal reflection was followed by an improvisation. The client suggested the title 'Being raised up' as the title for the improvisation, and requested the song "You raise me up". "You raise me up" had been used for the movement component earlier in the session, during which the client had responded with strong, engaged interpretive movement.

As the improvisation began, however, the client's energy and mood were low and quite incongruent with the verbal reflection and intention for the improvisation which had to do with courage, putting her foot down and being raised up. The client averted her gaze, unusually did not make eye contact, seemed to stare ahead in a blunted, vacant manner, sporadically playing the wind chimes which she had chosen and only sang intermittently and quietly (I11 6l). The audio clip starts at the end of the song as an improvised section begins where the therapist is supporting and reflecting the client's musical expression through plucking and harmonics on the guitar.

4.5.3. Difficulty (AM71, AM280, AM 11)

The third aspect of this theme deals with the varied difficulties clients seemed to experience within music making. Examples from the data include:

a) **Physical difficulty** - did not control positioning of the drum (H3 1e), hears pulse but cannot control playing (due to tremor) (H8 1f), tambourine seemed to control tremor better than hand drum (H8 3n), tremor impacts fine motor control (H8 5h), struggles to hold drum (M3 1b), struggled to physically hold the drum (N7 5e), struggles to hold bigger drum (P3 2a),

b) **Difficulty within the music** – difficult to find tonal centre (E5 3i) difficulty playing with slower pulse (I3 5f), difficulty playing solo section within pulse (J3 5h), could not hold pulse while counting when therapist played (N7 5f), difficulty slowing down (S3 4f), difficulty structuring sequences (S7 6g), difficulty remembering and mirroring multimodal rhythm (G6 2e), difficulty accessing new ideas the longer the exercise continues (Q14 4k), experiences sung dialogue as difficult (H11 4c), rhythm played loosely due to co-ordination difficulty.

4.5.4. Rigidity and perseveration in musical material (AM19, AM 20, AM48, AM 58, AM72, AM 98, AM 121, AM 204, AM 215, AM 225, AM 251, AM 275, AM 285, AM 288, AM 289, AM 294, AM309)

This sub-theme expresses difficulty and disturbance with reference to sameness, going through the motions, repetition and stuckness. In music these qualities are experienced and described in different ways. The data indicate many examples which, in one way or another, apply to all clients. Selected examples will highlight the extent of this sub theme which include affective and musical forms of rigidity and perseveration:

4.5.4.1. Affective quality

Data examples include: laboured quality to music (A3 5k), playing has dull, heavy quality (B3 1c), music has slow, lagging quality (C3 1i), dull quality perseverative (C8 1i), music has flat, dull quality (G4 1b), plays 4.4 rhythm, dull quality and perseverative (P8 6a), voice mirrors blunted affect (H11 5c), quality of movement blunted (O12 6d), no expression in music (P8 2e), sings phrase repeatedly in blunted manner (P11 4c), facial expression and affect blunted (S5 3h), remained in blunted state when therapist tried to engage her (S5 3m), varies rhythmic material but quality of music remains heavy (C4 1h), music has monotonous, heavy quality (H11 3h), robotic responses to changes in the music (S5 3g).

4.5.4.2. Repetition

This refers to the tendency of some clients to repeat musical ideas either as modelled by the therapist or that they may have initiated. Examples from the data include:- tend to repeat similar movement ideas (G14 4f), movements are slow and repetitive (M14 3c), repeats movement and requires prompting to change (Q14 3d), does similar movements during next turn (R14, 4e), repeats same melodic material (E8 5r), repeats vocal material (H5 3k), added lyrics which were repetitive but voice more flexible (P16 2g), repeats similar rhythms when his turn (Q6 2i), repeated similar ideas, some rhythms fragmented (S6 2c).

4.5.4.3. Lack of variation

Due to the phenomenon of sameness present in clients' musical expression, interventions focusing specifically on introducing variation were included. For some clients this remained an area of difficulty as illustrated in the following data examples: - does not vary movements (E12 7h), moves to music but no

variety (G12 1b), movements similar to previous sessions (O14 4a), music does not vary (F8 2k), does not vary music but responds to interventions (G4 2k), does not vary voice (j15 1c), does not adjust to tempo change (P11 2e), rhythm does not vary but energy higher, did not adjust music to therapist's intervention (E8 7ad), does not adjust to meter change introduced by therapist (O3 2j, Q3 4l), on hand drum did not adjust to therapist's intervention.

4.5.4.4. Rigidity and perseveration

As a point of clarification for the presentation of these findings, the term rigidity refers to fixed musical patterns expressed in quality and content, e.g. the client may respond to a musical change but returns to rigid repetition of the musical pattern. Perseveration refers to monotonous, ongoing, repetitive musical quality even when varied or disorganised musical patterns are present.

The music of Client P (SS), was consistently described as rigid due to her fixed rhythmic and melodic ideas. Examples from the data describing this aspect of Client P's music include: - established rigid rhythm on woodblock (P8 1d), played rigid rhythm on hand drum (P8 1h), continues with rigid rhythm when therapist changes meter (P3 2i), played rigid, perseverative rhythm (P8 2c), sings two lines in rigid fashion (P8 5h), melody is rigid and extremely perseverative (P8 7g), only responds to one tempo change but voice and melody remain rigid (P8 7j). These examples span the 8 music therapy sessions.

Video clip 2 (Rigid patterning on instrument)

This video excerpt, taken from Client P's (SS) first session, illustrates one such rhythmic pattern played on the woodblock. The client looks at the instrument throughout, except for one fleeting glance at the therapist, and only stops playing this pattern when the therapist invites her to change instruments.

References to perseveration in the data are numerous and span most clients representing both diagnostic groups. A few such examples from the data include:- music perseverative and fragmented (I3 1d), plays similar, perseverative rhythm when invited to change her rhythm (I3 5c), rhythm strong but perseverative (M3 1d), plays steady rhythm which becomes perseverative (M3 1d), music not as varied, more perseverative (N3 5h), rhythm quiet, fragmented and perseverative (O3 2a), started with different rhythm which became perseverative (P3 3b), varies rhythmic material but quality of music does not change (C8 1h), playing on xylophone becomes perseverative (J8 5a), perseverative although varying rhythm occasionally (N8 2c), music disorganised and perseverative (Q8 7k), tendency- new musical idea evoked by therapist which then become perseverative (E3 6i), client unaware of music intervention and continues with perseverative

music (E3 8j).

Audio clip 10 (Track 10 – Fragmented perseverative music)

This audio clip is taken at the beginning of a djembe drum improvisation with client I (MDD), session 1. What this clip illustrates is the client's natural 'default' playing, pre and post a musical intervention. Her natural musical playing is fragmented and perseverative, which is difficult to match and would continue with little variation, without an intentional musical change. Whilst the intervention offers a contrasting experience of playing a steadier, more regulated rhythm when the client is invited to play anything she wished she reverted to fragmented, perseverative drumming.

This theme highlights the presence of difficulty and disturbance, experienced in varied ways, in musical participation.

4.5.5. **Comparative findings – Theme 4** (Disturbing and difficulty)

This theme indicated areas in which difficulty is experienced or disturbance expressed within active music making. Some clients engaged in musical participation in a limited manner with regard to body language and space, within the music and with regard to accessing musical ideas. The data indicate that whilst this did not apply to all clients it did apply to clients from both diagnostic groups. Representative of both diagnostic groups was the occurrence of musical expression (e.g. energetic) being incongruent with non- musical presentation (e.g. blunted affect) or vice versa. Again, whilst this did not apply to all clients this did occur within both diagnostic groups. Clients from both diagnostic groups experienced other areas of difficulty within music making which related to physical difficulties such as holding or positioning an instrument as well as difficulties within the music itself such as not being able to hold the pulse or remember a rhythm. This was experienced by clients from both diagnostic groups. Perseveration and rigidity characterised the music of many clients from both diagnostic groups. Perseveration was evident in the affective quality of the music, which mirrored the blunted affect and low energy of most clients which seldom varied at the clients' initiatives. Perseveration was also evident through the tendency of clients to repeat their own musical ideas or copy ideas or promptings initiated by the therapist without being able to vary the musical material in any way. In terms of varying musical expression, clients from both diagnostic groups experienced difficulty with this. Rigidity in musical expression was primarily evident in one client from the SS-group.

4.6. Theme 5 – Turning points

As has been the case with other themes, this theme will be discussed with reference to extent of response. This theme refers to affective, energy and musical shifts which occurred during music therapy sessions.

4.6.1. Retreating to familiarity (AM297, AM50)

To experience a shift requires adjusting from one position to another. This may mean venturing from a default position or from a position deemed familiar and safe. Furthermore, being unfamiliar with musical vocabulary may also make it natural to relate to what is personally known and difficult to extend beyond that which is musically safe. The data illustrate numerous examples of clients playing what is described as their 'characteristic rhythm': - starts with characteristic rhythm (E3 5b, E3 6a, O3 5a, O3 6a), plays characteristic quaver rhythm (I8 6c), plays characteristic fast quaver rhythm (J3 6a), plays conga with characteristic rhythm (N3 4a), plays characteristic rhythm on djembe drum (P3 6a). The data also refer to instances where clients returned to an original form of musical expression: - reverts to original rhythm after short time (Q3 5d), reverts to original rhythm (Q3 6c). The goal of therapy would always be to facilitate growth and development and provide opportunities for clients to venture beyond the known to a broader range of musical and self- expression.

4.6.2. Shift in musical quality (AM06, AM10, AM 53, AM70, AM 128, AM 134, AM 146, AM205, AM, 263, AM 283, AM284)

Whilst the data highlight instances of fixed or limited musical participation, also indicated, are numerous examples which refer to shifts in clients' musical expression. These will be discussed with reference to changes in the music, shifts in quality of engagement and emotional response.

4.6.2.1. Changes experienced in the music

Many references from the data indicate shifts across varied aspects of active music participation. These include: varies melodic material (E8 6k), begins to extend range and vary melodic material (P5 3e), varies dynamics and tempo (A11 6o), dynamic level louder than previous session (E8 5j), drumming louder and more solid (E3 6b), varies music in relation to therapist's music (C8 1o), introduces and varies new musical

material (F3 3g), more varied, expressive movement (F14 4d), Varies manner in which he plays the instruments (G8 4h), varies music as story develops I11 5b), develops more defined rhythm (D8 5j), starts with rhythm uncharacteristic from previous sessions (E8 7g), plays different rhythm when therapist plays pulse (Q3 6b), starts with different rhythm (T3 4a), made use of contrasting musical elements (A11 3h), responds to contrasts in the music (H3 4aa), playing is contrasting and explorative (I11 8f), breaks perseverative patterns (P8 6d), focused and rigid patterns are interrupted (P8 7r), varies movements, hands (tremor) less noticeable (H14 2c), broadens repertoire of movements in subsequent turns (Q14 3c), larger, more varied movements (Q14 4d).

These examples suggest that the capacity for development and broadening the range of expression in musical response is possible. It is possible to vary limited musical expression, break rigid patterns, broaden musical vocabulary and stimulate different musical responses.

Audio clip 11 (Track 11 - Shifting rigidity)

This audio clip is taken from session 7, Client P. Prior to what is heard on the clip, client and therapist were engaged in a vocal improvisation. The client had initiated a melody which she sang repeatedly for a 3 minute period. The therapist had introduced a key and tempo change that the client seemed not to hear, repeatedly singing the rigid melodic pattern. The clip begins where the therapist invites the client to sing a different melody. There is a pause and the client says “I’m stuck”. In response the therapist initiates a new melody which they jointly sing. After a period of time the therapist again invites the client to sing a new melodic idea. This time, without hesitation the client sings a distinctly different melody that client and therapist continue to develop. This shift in musical rigidity signaled a significant moment in the process with Client P.

4.6.2.2. Shifts in energy and engagement

Synonymous with changes in musical qualities are corresponding shifts in other areas. The data indicate that clients experienced shifts in quality of engagement during active musical participation. Examples include: - shift from passive to active participation (I12 1h), momentarily mood lighter and engaged in present moment (S14, 3k), shift in engagement and energy with known song (S8 4e), shift in music, energy and focus from earlier sessions (S8 8q), gradually increases energy of her music (A8 6aa), energy levels higher at conclusion of improvisation (H11 2g).

There are also references in the data which indicate a change in energy levels from higher to lower. Whilst theme 6, *Energy bursting and lacking*, illustrates the full extent of energy levels experienced in active music making, it is noted under this theme that shifts to lower levels of energy and engagement also occurred: - e.g. loses interest after short periods of engagement (H12 1f), gets tired (H12 1g), playing loses momentum (M8 3d).

Audio clip 12 (Tracks 12aa and 12ab - Shift in musical engagement)

These two audio tracks illustrate the shift in Client F's music and quality of engagement from Session 1 to Session 8. These brief excerpts demonstrate Client F and therapist engaged in an instrumental improvisation. On both occasions the client plays the woodblock and the therapist the piano. This client is very musical, having been a professional musician in his early twenties. He had stopped playing music for many years. In session 1, whilst his musicality was evident, more evident was his lack of self-confidence and pronounced low mood, starkly seen in his facial expression. Track 12 aa illustrates his sense of rhythm, but more so the limited manner and range with which he plays the woodblock. The interaction between client and therapist is also limited. In contrast, Track 12 ab is an example of a similar improvisation that took place during Session 08. Client F plays the woodblock in a more creative, complex manner and the interaction between client and therapist is both playful and resembles two musicians playing with elements of call and response present in the music. The shift in musical quality between these two examples reflects the general process with this client as he developed over time, broadening his range of musical expression and reconnecting with music.

4.6.3. Weeping (AM73, AM265)

The last section of this theme illustrates a few examples which refer to emotional responses elicited by the music: - weeps during movement exercise (H12 6e), became emotional and quiet as we played the drum (R10 2e), became emotional when playing the drum (S11 3c), experienced drumming as emotional (T3 1c). During movement Client G 'became emotional and quiet' (camera did not record, taken from therapist session notes: Client G, session 6).

The following vignette provides an example of how musical particpation elicits an emotional response:

Vignette 4.1

Client R (SS) arrived for the second session and was resistant from the very beginning. She expressed

anger and frustration about being confined to the hospital. The client resisted participation in the relaxation, opening drumming, movement, vocal and Receptive Music Therapy components. The therapist suggest that the session be concluded with a djembe drum (client) and piano (therapist) improvisation. The therapist reminded Client R of the first session during which she had stated that she had experienced the drumming as a release. The client's response "*I don't have the power, I can do it softly, I don't even feel like'* was congruent with how she had presented throughout the session. As the client began drumming she became tearful, averted her gaze and continued playing the drum. She wept for the most part of the improvisation, but did not stop playing. The therapist supported the client's music reflecting something of the emotional quality present in her music. At the end of the improvisation Client R apologises for becoming emotional (*'sorry about this')*, is quiet for a while and then voices her frustration about the daily routine at the hospital (*sit, sit, sit, sit, sit)*. The client states that perhaps she will feel better, when invited by the therapist to consider coming back for the next session.

This example suggests that a shift in emotional response, through musical participation, contributed to Client R tentatively moving towards openness and away from resistance.

It is always the goal of therapy to journey with clients in such a way that development and growth is made possible. This theme illustrates potential turning point moments in therapy when shifts in energy, engagement, musical quality and emotional response occur.

4.6.4. **Comparative findings – Theme 5** (Turning points)

This theme is expressed through moments of change within musical expression evident through shifts in energy, shifts in levels of engagement, changes experienced in musical qualities and through musical participation eliciting emotional responses. There were clients for whom change within musical participation was difficult or limited. These clients, representative of both diagnostic groups, tended to play similar, characteristic musical material from session to session only experiencing variation in musical expression at the invitation of the therapist. What this theme does highlight, though, is that clients from both diagnostic groups were afforded and responded to varied and contrasting experiences of musical expression, shifts in energy levels and manner of engagement and heightened capacity to respond through a broader range of musical expression. This theme also described how music making elicited an emotional response from some clients. Whilst these examples from the data are not numerous, it is noteworthy that they refer to both

diagnostic groups: i.e. two clients with major depressive disorder and 3 clients with schizophrenia.

4.7. Theme 6 -- Energy bursting or lacking (AM142, AM143, AM 144, AM145, AM147, AM148, AM152, AM180, AM228, AM230, AM269)

This theme discusses the quality and extent of energy expended during active music making.

4.7.1. Qualities of energy (AM144, AM145, AM151, AM 152, AM228)

The data provide varied descriptions of the quality of energy observed in clients. Descriptions include bursting energy, lethargy, dull, and tight energy: plays conga with bursts of energy (M5 4e), offers bursts of musical energy (H3 4k), voice and body heavy, dull quality (C15 1o), lethargy results in not holding the drum properly (M3 2c), plays in lethargic manner (M8 2j), yawns after louder singing (S15 3h), tight energy (A12 1h), movement was animated and energetic (J12 1b).

4.7.2. Extent of energy

Numerous references in the data describe energy levels across the spectrum of low to high which includes lower, higher and high and manic energy. Examples from the data include:

a) Low energy: tired (A12 1k), client mood and energy low (D8 5a), low energy (E12 6l), although energy low works with increased tempi and energy in the music (L15 2p), energy low and facial expression blunted (P3 3a),
b) Lower energy: - music loses energy (A8 6o), gets tired (H12 1g), initially moves with limited energy when invited to move (L12 1b), slowed tempo, less energy during joint improvisation;
c) Higher energy:- increased energy(A5 3w), shift to higher energy (A8 4w), end energy higher (E3 2m), played with more energy than previous session (E8 7v), energy levels higher at conclusion of improvisation (H11 2g), more energy in music (I3 8c), swayed body and engaged with higher energy (N8 7l), played drum with more energy for brief while (S5 3k),
d) High energy: - music loud and high energy (A3 2c), music high energy (A11 4i), high energy playing (D11 5c), end jointly high energy (E3 1k), plays high energy drum roll with therapist (Q3 5l), played high energy, fast rhythm on djembe (R3 4a), not being able to end evolves in high energy turn taking (R3 1h). Three references in the data refer to high musical energy that had an elated quality: - shift in

energy which has elated quality (M5 3f), elated quality to client's energy on the conga (M16 3j), elated disinhibited quality to her playing (R3 1i). In the case of these two clients, both presented with low energy at the start of their sessions respectively.

Two observations from the data should be noted:
Firstly, of the twenty eight references to energy during movement activities (AM230), only six refer to low energy. The balance of the energy and movement references describe energy as energetic (D14 3h, H12 4c, J14 4c, N14 4d) higher energy (I14 3e), more energy (E12 4i, L12 1d, O14 4i, P14 4d), quicker response (N14 3d), more energy than usual (Q12 5a),

Secondly, of the 36 references to energy and joint music making, all references referred to heightened energy levels: - energetic musical interaction (A5 4n, D3 4e, D11 5i, F11 2g, H3 6k, H3 8d, N6 2j, R3 1l), high energy (D11 5c, E3 1k, F4 4k, G11 3f, H3 3i, J3 5j, R4 1g, R3 4g), higher energy (E3 3n, H15 2j, H3 3j, S3 4g).
Both diagnostic groups are included in these references. The data indicate that participation in music-centred dance and movement activities as well as music making within the context of a therapeutic relationship facilitates heightened energy levels affording clients the experience of shifting between energy states.

4.7.3. **Comparative findings – Theme 6** (Energy bursting and lacking)

This theme described the extent of energy levels present within musical participation. Both diagnostic groups were represented across the spectrum of musical expression comprising low, lower, higher and high energy levels respectively. Of particular emphasis in this theme is the response of clients from both diagnostic groups to music making and, in particular, to movement. Herein clients representing both diagnostic groups responded to musical and movement participation indicating a shift from lower to higher energy levels.

4.8. Theme 7 - Bodily synchrony

The music therapy intervention incorporated a movement component during each session. Movement activities included seated mirror image exercises, dancing, dancing combined with instruments, interpretative movement and use of body percussion. The response of clients to movement exercises and

the use of body in music making varied from person to person. The data indicates that for most of the clients movement came naturally and was a modality with which they connected and felt comfortable. For others, either due to the impact of pathology, medication or personal preference, movement and use of body was experienced as more challenging.

4.8.1. Difficulty with movement (AM 08, AM100, AM126, AM217, AM256)

Examples from the data include: - tremor impacts playing of drum (H6 2m), tremor severe as client begins movement (H14 2a), movements faster than therapist due to tremor (H14 2c), tremor pronounced at start of mirror image, does not move naturally (G12 5c, G14 7d),aspects of stiffness in body (A14 4g), freezes when it is her turn (J14 2d), movement frozen in the beginning (O14 2a), indicates difficulty dancing due to sore hip (R12 1a), danced in spite of sore hip (R12 1g), slows down and closes her eyes (L15 2i), sings alone eyes closed.

4.8.2. Connecting with movement (AM07, AM92, AM217, AM237, AM243, AM244, AM245, AM249, AM258, AM262, AM264)

As stated previously, the majority of references in the data suggest that clients connected with movement in an instinctive, spontaneous manner. To illustrate this examples from the data will be discussed with reference to: use of body, quality of movement, development in movement expression and creative interpretation. Examples from the data include:

4.8.2.1. Use of body

Data references include: - works whole body (E12 1f), uses whole body freely (H12 4d), moved with whole body, not just arm movements (I14 4f), swayed to opening section (E12 6b), spontaneously sways body to music H15 2k), swayed body and engaged with higher energy (N8 7l), low energy, swayed slowly to upbeat African song (R13 5b), spontaneously claps whilst singing (G163c), adds clapping to her rhythm (H62f), started mirror image clapping hands against mine (N14 3a), claps at the end of the vocal improvisation (T17 1f), dances independently (A12 1e), combines drama/dance with drum playing (A11 7l), danced, using varied movements (P12 5c), instinctively clicks fingers and moves legs (F12 1d), started with line dancing movement (T12 7b).

4.8.2.2. Quality of movement

Movement is natural and creative (E12 5e), moved naturally to the music (E12 1b, I12 1f, J12 1a, K12 1a, M12 5c, O12 1b), moved naturally and expressively (j12 6c, J12 7b), moves naturally and with energy(N12 5c), moved naturally and freely (O12 5b, S12 7b), movements are physical and dramatic (I14 4g), moves body freely (A14, 4i), moved freely and spontaneously (I12 7e), uses more free, creative movement when standing (R14 4g), Large movements (A12 6f, A14 4d, A12 6f), conclude mirror image with larger, flowing movements (H14 2d), movements large and slow(P14 4b)

4.8.2.3. Development in movement expression

As the sessions progressed interventions were introduced to extend the clients' experience of the use of movement. The data demonstrates examples of this: - uses more free, creative movement when standing (R14 4g), sustains drum/clap, on/off beat section (G12 5j), uses larger movements (E14 3d, E12 4d, I14 3a, O14 4c), gradually uses larger movements (D12 5d), tremor reduced during large movements (H14 2f), larger, more varied, energetic movements (N14 4d), movement becomes larger and more creative (T12 2g).
Another indicator of development was clients' use of space. The data indicate that some clients increasingly appropriated the physical space in order to engage more freely with movement. Examples from the data include:- uses more of the space (E12 4e, E12 7j, O14 4g), used larger space (F12 7c), uses space freely (J12 7c), uses whole space and dances freely (O12 1c), moves around whole space (A12 5d), uses whole space (S12 7c), used large space (T12 7c).

With the exception of one reference (O12 1c) that is taken from session 1, all other references are from the fourth session onwards, which may suggest increasing confidence in movement expression through reinforcement and familiarity.

4.8.2.4. Creative interpretation

Throughout the music therapy intervention clients were encouraged to lead, initiate ideas and interpret music through movement as freely as they wished. Examples from the data include: - own movement interpretation (H12 7a), interprets movement from start of song (I12 6c), spontaneously interprets what she is singing through movement (J8 5g), ends with hands in 'prayer' position (P12 6g), sings and does

interpretive movement simultaneously (S12 6c), adds interpretive movement (S8 8p), works sensitively with the music interpreting movements (T12 6e). This theme demonstrates the varied ways in which clients in engaged in bodily expression within music making and movement.

4.8.3. **Comparative findings – Theme 7** (Bodily synchrony)

This theme described the manner in which clients engaged with the movement component of the music therapy sessions. Difficulties with regard to movement and use of body were described. Clients from both diagnostic groups are included in these descriptions. Also described within this theme is the manner in which clients connected with movement. Common to both diagnostic groups is the instinctive, natural way in which clients moved in response to music. In addition clients from both diagnostic groups demonstrated a capacity for spontaneity and expressiveness as well as increased confidence resulting in more flexible and expressive use of the body in movement over time. Furthermore, the data suggest that clients from both diagnostic groups interpreted movement creatively in response to the music.

4.9. Theme 8 - Intensified emotional expression

Musical elements such as dynamics, tempo, timbre and rhythm, in varying combinations, convey emotional qualities within the music, and make nuanced and varied musical expression possible. In the case of some clients, as previously discussed, the music was limited, blunted or interrupted often within a narrow expressive range, especially in earlier sessions. Emphasis was placed on broadening and deepening the range of musical expression throughout the process of therapy.

The findings will be presented with reference to emotional intensity expressed in musical dynamics and musical sentiment.

4.9.1. Emotional intensity expressed in musical dynamics (AM81, AM 96, AM131, AM132, AM133, AM137, AM138, AM140, AM197, AM211, AM238, AM293)

As with other aspects related to musical participation in this study, such as energy, engagement and awareness, a spectrum reflecting extent of response is described. So it is when describing how clients used dynamics in musical expression. Examples from the data include:

Piano (soft, quiet) – voice quiet (A5 4c), starts quietly (D8 2f), quiet rhythm(D3 3e), ends quietly (D8 4aa), client's paying is quiet, runs fingers across wind chimes (E11 7g), sings quietly and intermittently (G8 1o), voice is quiet and plays expressively (J8 3p), played and sang quietly (L11 1b), ends improvisation quietly and slowly (O4 1m), continued to play in rigid fashion, sang quietly (P8 1f), plays quietly on the tambourine (S8 7a), plays soft, strongly pulsed beat (18 6e), plays soft rhythm which she varies (O3 1b),

Calando *(quieter)* – during improvisation voice quieter (A15 2g), playing starts strongly and becomes quieter (G11 5d), ends improvisation by playing quieter and slow (O8 2s), playing quieter and slower at end (R11 7g),

Soave (gentle) – gentle quality (D12 5e), moves in gentle and carefree manner (E12 7f), joint music legato and gentle (E8 3j), music is gentle (F8 7q), quality of music is slow and gentle (T8 7d), joint music has gentle quality (O8 6g), joint singing has flow and gentle quality (T17 1e),

Leggiero *(*light) – taps drum lightly (C11 1d), music light and steady (D8 4g), reflects the theme through lightly tapping o the drum (G11 8b), begins to lightly beat drum (G11 8c), light rhythm (E3 2c), played light melody on xylophone which therapist mirrored (R11 7b),

Forte *(* loud, louder) –music loud and high energy (A3 2c), music loud and angular (A3 5s), drumming louder and more solid (E3 6b), music becomes fuller and louder (E11 7i), sings loudly (G15 3h), uses voice loudly and more spontaneously (H3 4i), played xylophone in loud, child-like manner (H8 7b), loud, steady rhythmical rhythm (N3 2b), voice louder with known song (D8 3y), begins to sing louder (F5 3p), initiates loud, energetic drum roll (H3 5e), drumming was louder, (O3 7h), sings louder than previous sessions (Q15 3b),

Vigoroso (Intensity) – movement increases with intensity as music builds (A12 6j) played the drum fast, with intensity (I11 2c), movements become stronger as music intensifies (E12 6g), plays strongly and intensely (F8 7l), plays drum with intensity (I11 3c), varies rhythm building with intense short bursts (I3 6c), gradually increases intensity of playing).

4.9.2. Musical Sentiment (AM76, AM83, AM91, AM93, AM 101, AM103,AM110, AM115, AM181, AM185, AM239, AM257, AM272, AM290)

In addition to describing clients' music in terms of musical dynamics, the data also indicate emotional sentiments ascribed to musical expression. Where applicable, formal musical terms are used to capture these sentiments in the data. These include:

Espressivo *(*expressive) – music has flow and is expressive (F8 7r), starts playing with clenched fist (G11 5c), played tambourine in varied and expressive manner (J8 2k), voice is quiet and plays expressively (J8 3p), sings expressively (J8 5h),

Pesante *(*heavy, laboured) – playing has dull, heavy quality (B3 1c), music has dull, heavy quality (C4 1c), played drum in heavy, dull manner (H11 3d), music has monotonous heavy quality (H11 3h), voice and body heavy, dull quality (C15 1o), tempo laboured (A8 2f), plays in laboured manner (M3 2a), plays rhythm in laboured manner (M3 4b), music has laboured, heavy quality (Q3 2e), rhythm laboured but steady (Q3 6a),

Affettuoso *(*warm, sensitive)- joint music legato, warm quality (A8 5l), joint improvisation warm quality (D8 4y), warm quality in joint vocal work (N15 3d), sings song with sensitivity (P16 1f), plays more sensitively but cannot regulate to slower tempo (R8 4g), works with music sensitively interpreting words through movement (S12 6g, T12 6e),

Patetico (poignant) – end on poignant note (J12 6f), poignant moment (S11 7k),

Sforzando (forceful) – playing is forceful (Q8 7g), playing loud, forceful (F3 3n),

Risoluto and forte *(*bold, strong) – strong movements (A14 3i), starts with strong, large movement (I14 4d), strong music (A4 1q, A4 1z, A11 5g), ends improvisation strongly (D3 3m), joint improvisation strong and interactive (D3 4v), starts with strong, steady rhythm (E3 4s), call and response, intense and strong music (F11 1l), played single strong beat in response to therapist's final beat (G3 1f), strong, definite music (G3 6d), ends improvisation with strong, sustained note (P8 4q) joint music strong (H3 4g), rhythm strong but irregular (J3 5c), rhythm strong but perseverative (M3 1d), rhythm on conga drums strong and steady (N8 6a), playing is strong (O4 1h).

Two additional references that do not fit in any of the above mentioned descriptions are: irritation seemed present in music (S3 4i) and joint playing busy (M8 8d). Whilst the scope of this study did not include tracking the therapeutic process with each client over time, there is evidence of more nuanced, deepened expression in later sessions, as illustrated in Tracks 15, 16, 17, 19.

The following audio clips illustrate six brief examples of sentiment expressed musically.

Audio clip 13 (Track 13 – Musical sentiment: dull and heavy)

This audio example is taken from session 1 with client B (MDD). The client begins playing the djembe drum in a heavy, dull and irregular manner. The therapist plays lighter fill in beats and encourages the client to add

additional beats. The client occasionally varies the rhythm but with the quality of his music remains laboured.

Audio clip 14 (Track 14 – Musical sentiment: expressive singing)

Client J (MDD) arrived at the final session stating that she wished to sing me three songs, one of which was a cultural African song. The song depicts a rural scene with animals – frogs and owls. The audio clip illustrates the client's expressive use of voice to convey the meaning of the song. Humour is shared between client and therapist as the song progresses.

Audio clip 15 (Track 15 – Musical sentiment: sensitivity)

As previously stated, Client F had worked as a musician in his early working years. He had not engaged with music for a long period of time. The music therapy process reawakened his connection to music. During session 2 the client recognised the song *"Misty*", which was used for the opening relaxation piece, and indicated that he would like to play it. In subsequent sessions *Misty* was incorporated as the basis for joint piano improvisations. This audio clip, taken from session 7, illustrates the client's musical sensitivity. He plays on the higher register of the piano while the therapist provides melodic and harmonic support in the lower register.

Audio clip 16 (Track 16 – Musical sentiment: strong and warm)

This audio clip is an excerpt from session 5, Client A. Client and therapist are engaged in a free improvisation. At the start of the clip the client is playing the Conga drum whilst the therapist sings and clicks fingers. The video example illustrates the client's increasingly engaged body language which is heard through strong, accented music which she initiates. The therapist joins on the piano and matches the client's strong, energetic music. A warm interactive musical exchange ensues, leadership is shared and laughter exchanged at the end.

Audio clip 17 (Track 17 – Musical sentiment: forceful)

This brief audio example is taken from an unstructured instrumental improvisation with Client Q (SS), session 7. He selected the xylophone and began playing in a forceful and sporadic manner. The therapist matches this quality on the piano.

Audio clip 18 (Track 18 – Musical sentiment: gentle and slow)

During a free improvisation with Client T (SS), session 7, he selects the windchimes and tambourine. His music is gentle and slow. The therapist supports his music by playing light arpeggio chords on the piano. The client spontaneously begins singing a quiet, gentle improvised melody which the therapist supports through voice and piano.

4.9.3. Comparative findings – Theme 8 (Intensified emotional expression)

Described above is the manner in which emotional intensity is expressed by clients through musical dynamics, as well as various musical sentiments which were expressed during active music making. Both diagnostic groups are represented in these descriptions. The data indicate that within the context of music making, clients are afforded nuanced experiences of musical expression, some of which are contrasting to daily lived experience either with regard to intensified feelings in the case of clients who present with low mood and energy, or in the case of clients for whom perseveration and disorganization compromises the subtleties and extremes of musical expression. Within the supportive, co-creative music therapeutic relationship clients are offered more textured musical and relational experiences.

4.10. Theme 9 – Exploring new territory

Throughout this discussion reference has been made to shifts clients experienced through musical participation. Shifts in engagement, energy, levels of awareness, musical-emotional and bodily expression have been evident from the data. This theme, 'Exploring new territory', will be discussed with reference to the following sub-themes: spontaneous music initiative, interactive musical thrill, musical exploration, recalling of process, confidence, musical sharing, and elaboration of musical qualities.

4.10.1. Spontaneous music initiative (AM15, AM32, AM42, AM51, AM79, AM133, AM255, AM184, AM206, AM241, AM242)

The prominent terms within this sub-theme are spontaneous, free, starts, initiates and changes. There are numerous references in the data to examples of these spanning all clients and both client groups. For the purposes of this discussion selected examples from a cross section of clients will highlight clients' spontaneous musical participation. Examples from the data include:

Starts: -client starts, no reticence (D3 5a), began drumming without invitation (F3 5a), begins playing

without hesitancy (G4 1i),

Changes: - changes instrument without prompting (D8 5u), client moves to drum at own initiative (E11 7b), moves to new instrument and introduces change in the music (F8 4g), responds to modulation, changes instrument and tempo;

Spontaneously:- (P8 5g), sings spontaneously, independent musical material (H15 2k), uses voice with increasing energy and spontaneity (J15 2g), stood, danced in spontaneous uninhibited manner (T12 1g), spontaneously stands as music builds (S12 6f), played spontaneously at end (O3 7f), spontaneously claps while singing (G16 3c), music is spontaneous and creative (H8 5t),

Initiates: - initiates contrasting music (A11 1f), initiates tempo and dynamics changes (A11 4d), initiates new rhythms (D3 2m), initiated new musical ideas (E4 1d), offers different vocal ideas (F5 3n), introduces a new song not known to therapist (H5 3s), suggests singing 'Hey Jude' (Q15 3a), initiates an improvised melody (T8 7c),

Free: - uses whole body freely (H12 4d), plays wind chimes freely without singing (J8 4c), joint playing free and unstructured (O8 5c), initiated free vocal singing (N3 8j), moved freely and spontaneously (I12 7e).

4.10.2. Interactive musical thrill (AM102, AM151, AM183, AM187)

The data highlight playful and humorous qualities present during interactive music making between client and therapist.

Examples from the data include: joint music playful quality (A8 7y), joint interaction playful (E12 4m, G4 1k, H5 3g, H8 8g, J14 4c, T3 4d), client's musical initiative set up playful vocal interaction (I5 3c), interaction relaxed and playful (J12 7f), joint movement interaction relaxed and playful (R14 4h), joint music strong and playful (H3 4y), joint humour (D8 3x, E41f, E12 5c, F15 2b, G15 3l, T11 7e), joint humour when mistakes made (E7 4o), joint humour when therapist does not mirror precisely (F6 2k).

4.10.3. Musical exploration (AM23, AM24, AM31, AM74, AM75, AM207, AM308)

The next sub-theme deals with the manner in which clients appropriated musical participation as a means for creative exploration and independent improvisation. In sessions 1-3, apart from a djembe drum improvisation in the early part of each session, only small percussion instruments were used for the

instrumental improvisation component. From session 4-8 the music space was extended to include a conga drum, wind chimes, a rain stick and xylophones. In general, the data suggest that as the music space opened up, so did the tendency for creative exploration. References cite primarily, but not exclusively, sessions 4-8.

Exploration: - creatively explored music space (G8 4n), offers new material through exploration of the music space (G8 7e), explored music space playing various instruments (H8 5n, N8 7b, O8 5d, P8 6c), explores music space playing quietly (I8 4c), not fragmented exploration of music space, music as coherent whole (T8 5f), explores different ways of playing the drum (F4 1g), plays in more explorative manner (C8 1k), explores and organises instruments (F8 4b), playing is contrasting and explorative (I11 8f),

Improvises: - Client F (previously a musician)- improvises on top register over blues chord sequence played by therapist (F8 6d), improvised naturally and effortlessly (F8 6a,b), improvises own words at therapist's invitation (H15 2l), when prompted look up and sings improvised melody (M8 3i), improvises song based on theme of love (P11 4b), improvise melody where therapist plays long phrases on guitar (Q8 8c) improvised moving between the light and the dark place (T11 6c), improvised words based on three circles (T11 7m), played tambourine and improvised melody.

These examples demonstrate the musical expression of the client being extended in the music space, venturing into new creative territory through exploration and improvisation.

4.10.4. Confidence (AM26, AM66, AM84, AM99, AM106, AM111, AM116, AM117, AM177)

For most clients in this study, participation in music was a new experience. Initially these clients presented as unsure, lacking in confidence and hesitant. In order to venture towards exploration and improvisation required affirmation and support on the part of the therapist. Some clients, on the other hand, exhibited higher confidence levels from the start and engaged in musical participation accordingly. The examples from the data illustrate a spectrum of confidence levels and will be discussed with reference to low confidence, hesitant to engage and gaining confidence.

Low confidence: - lacks confidence (D4 2e), dismisses ability to sing (H15 2a), dismissive of own music (F8 7z), needs more confidence (F15 5p) wanted therapist to lead entire mirror image (R14 4b), uncertainty (A17 1i), seems unsure of himself (Q15 1g), seems shy (D5 3f), embarrassed, shy laugh (F12 1b), asks therapist to start dialogue (T15 1g),

Hesitant to engage: - playing is regular with occasional hesitancy (A8 2c), hesitates at intervention (E3 6m), hesitated if therapist played something different (G3 1d, T3 5d) hesitates when therapist invites

him to continue playing (Q8 1e), hesitant about what to do (R3 3d), begins tentatively (D5 3m), tentative use of voice (F15 2r), voice tentative and quiet (G17 1b), reticence to start (D8 3b, D8 3w, D8 5d,) voice quiet and seems uncomfortable using voice (F15 1o),

Gaining confidence:- increasing vocal confidence (A5 3p), plays melodic instrument for first time (E8 5q), uses voice in uninhibited manner for the first time (H3 6j), music fragmented, but first time he plays two instruments simultaneously (Q8 5q), first time exploring music space unprompted (N8 6e), sings with more confidence (E15 1f), sings confidently alone (H15 2d), starts improvised section with confidence (I16 2f), sings with confidence and intention (J8 7f), second time sings with more confidence (L16 3h).

4.10.5. Musical sharing (AM175, AM182, AM188, AM189, AM190, AM194, AM195)

As stated in 4.2, interactive music making was central to the music therapy intervention in this study. This sub-theme discusses the constituents of joint music making illustrating how the shared musical space offered clients new opportunities for agency and creative expression. References to interactional music include most clients across both diagnostic groups.

The data will be discussed with reference to i) call and response and ii) negotiation and mutuality.

4.10.5.1. Call and response

Turn taking or 'call and response' played a central role within the Active Music Therapy component of the study. Some turn taking exercises were aimed at assisting clients with focus, concentration and providing structured 'here and now' experiences. These would require clients to work within a specific musical structure or e.g. copy rhythm, movement or melody precisely. In contrast to this, call and response techniques were also aimed at fostering creative, independent musical expression wherein clients were specifically invited *not* to copy the music of the therapist. References to call and response in the data include: - vocal dialogue evolves into joint improvisation (A17 1p), call and response – intense and strong music (F11 1l), echo each other (E17 1k), call and response pattern – client's tentative approach followed by immediate varied playing by therapist (G4 1h), evolves into drum/vocal dialogue of African songs (J5 3e), interactive turn takin in response to client's initiative (O3 2n), vocal improvisation call and response (T8 7h).

The structure of call and response can offer opportunities to explore new roles. Musical partners need not assume fixed roles. These roles can include, for example, leading and following, improvising and holding, and musical partnership within which mutual musical expression evolves. Reference to roles from the data include: alternate leading/following roles (E14 3e), swop roles holding pulse (D3 1l), solo section (F15 2p), swopping roles – client on piano (F8 5c), alternate client counting/own rhythm sections (M35f), alternate leadership and vary movement (P14 2f), developed varied repertoire of movements alternating turns (P14 3c), short turns, always varying rhythms (S14 2e) , client's response results in interactive turn taking (R3 5h), joint musical exchange holding (F5 3o), jointly play rhythms with therapist providing melodic and harmonic grounding.

4.10.5.2. Negotiation and mutuality

Roles, structure and musical expression need to be negotiated by players within a music space for the music to truly be regarded as a shared space. It is not uncommon, in the early stages of therapy, for clients to be uncertain about their role and to experience music making as unfamiliar. It stands to reason, then, that clients may respond as compliant or anxious in the first few sessions. For negotiation to take place both parties need to experience themselves as equal partners with an equally valued voice and that their contribution holds the potential to shape and influence musical expression and interaction. What this implies is that more and more room is created for music to be mutually created, rather than led by the therapist.

The data highlight varied examples of negotiated, mutual musical moments: - jointly negotiate tempo change (A17 2h), music jointly negotiated with contrasts (A171q), jointly create anticipation (D8 3ak), jointly anticipate pauses (F11 1g), jointly increase tempo and negotiate end of improvisation (J3 6k), jointly increase energy and end with high energy drum roll (R4 1g), alternate and jointly vary rhythms (S 14 2d), give and take in musical partnership (T8 8h), joint playing mutual with client taking more initiative (F3 3h), joint playing is mutual and has flow (F8 7t), joint music making increasingly mutual (I8 7h), mutually responded to contrasts and musical ideas (T8 8g)

Audio clip 19 (Track 19 - Negotiating the music)

This audio clip is taken from session 8, Client T (SS). The clip illustrates the aspects of call and response, negotiation and reciprocity. Both client and therapist influence the direction of the improvisation atdifferent

stages of the improvisation. There is no clear leader although there are times where either client or therapist introduces changes within the music. The video clip (not able to be viewed for ethical reasons) illustrates how the client maintains eye contact with the therapist being fully aware of the mutuality of roles and musical expression.

4.10.6. Recalling of process (AM 44, AM45, AM47, AM301)

This sub-theme deals with clients' recall of various aspects of musical participation in the moment and across the therapeutic process. The data suggest that as musical expression is remembered, that further reinforcement and development is possible.

Examples from the data include:- recall piece of music from previous sessions (F8 6a), gradually remembers rhythms through therapist's direction (M7 6d), managed three rhythms without reminders at the end (M7 7d), the more we play the rhythms the more she is able to recall them (P7 6g), remembered vocal work from previous session (Q15 2a), remembers words of song better this session (Q15 3e), remembered to cue therapist for her turn (S14 3d), recalls rhythm from previous session (E8 2q), recall of all chords (F16 3c), recalled Piano Man from previous session (Q15 2e), the more we practiced the greater the client's recall of the structure of each rhythm (S7 6h), jointly sing vocal improvisation theme from earlier session (T8 6j)

These data examples refer to clients from both diagnostic groups. The data suggest that participation in active music making stimulates recall and makes possible learning, performing and developing musical material.

4.10.7. Creative elaboration of musical qualities (AM17, AM25, AM65, AM122, AM123, AM201, AM208, AM224, AM226, AM232, AM234, AM240, AM291, AM295, AM300, AM303)

The final section of this theme describes what the data suggest as elaborations of musical qualities. This refers to varied ways in which clients extended their musical expression. This will be discussed with reference to elaboration of the self in music and elaboration of the music.

4.10.7.1. Elaboration of the self in music

In this chapter, reference has been made to the emphasis placed on agency and independent musical expression. An integral aspect to the music therapy intervention was offering a space to clients in which they could experience autonomy in self-expression. The data indicate that this was evident through leadership and independent musical material:

Leadership – Earlier in the discussion reference was made to the fluidity of roles between client and therapist. The therapist was intentional about offering musical leadership opportunities within various components of the intervention. This is linked to 4.10.5 where roles and musical negotiation were discussed. Assuming leadership, however, is also described as an elaboration of the client's role. The data describe the following: - led theme improvisation (A11 5f), takes leadership (A11 7q), client sings and leads Zulu song (D8 4v), alternate leadership roles (E12 1c), leads mirror image (E14 3c), when her turn to lead uses large movements (H14 2g), leads the song with drum and voice (J11 4d), sings short phrases and gestures to the therapist to sing (Pf 3a), assumed leadership indicating therapist's turn (S14 2b), leads improvisation in varied and creative manner until end (T8 7m).

Independent musical material – Whilst it was the tendency of some clients, primarily in the earlier sessions, to copy the musical material of the therapist, every effort was made to encourage clients to play their own musical ideas. Most clients were able to do so during the eight sessions. This represented clients' extending themselves in the music space. The data include the following examples: - dances independently (A12 1e), independent rhythms (A6 2k), responds with independent musical material (C4 1b), joint improvisation each sing independent musical material (E17 1i), independent music ideas (F4 1f), independent vocal material (G16 4k), sings spontaneously, independent music material during improvised section (H15 2f), does not copy when therapist plays multi-modal rhythm (M4 4d), each moved with independent movements (F12 5a), offers independent movement in response to intervention (L12 1h), sings independent vocal material during dialogue (S5 3i).

4.10.7.2. Elaboration of the music

The data provide varied examples of aspects of musical elaboration. These include: - extends melody and sings long phrase (A15 7g), explored melodic material (F8 5n), begins to extend range and vary melodic material (P5 3e), extends improvisation when Th tries to end (D3 5j), extended vocal range (O15 3d), uses

broader range of movements as exercise progressed (O14 3e), develops more defined rhythm (D8 5j), manages to mirror multi-modal rhythms over time (G6 2h), develops steady rhythm on tambourine (S8 2g), towards the end introduced creative movements (K12 1h), energetic and creative movement when combined with instruments (R13 5c), movement becomes larger and more creative (T12 2g), begins to extend movement repertoire (F14 3k), extending range of movement (N14 3b), sings with expressive body movements (I11 7e), combines drama/dance with drum playing (A11 7i), dramatising movement to the music (T14 4h), can mirror multimodal rhythm (N6 2c), more complex rhythm than in previous sessions (E3 8e), third rhythm more complex (F6 2j)extends rhythms (D4 2i), music is spontaneous and creative (H8 5t), improvised section interactive and creative (T16 4g).

The examples from the data show ways in which clients explored and navigated new musical territory. Words such as extend, develop, complex, combine, multimodal, spontaneous and creative suggest a dynamic evolving relationship between the client and music. Many clients appropriated the music as means to extend themselves intra- and interpersonally through various forms of musical expression.

4.10.8. **Comparative findings – Theme 9** (Exploring new territory)

This theme described clients' venturing towards new musical territory. This was evident through spontaneous music initiative which included the client starting musical interactions, changing aspects of musical material and spontaneously responding within joint musical interaction. All clients across both diagnostic groups are included in these descriptions. The data indicates that clients from the MDD-group tended to start musical interaction or initiate changes in musical material more so than clients from the SS-group. This theme also highlights the thrill experienced within joint music making. The relationship qualities of playfulness, humorous, interactive and relaxed were more evident with clients from the MDD-group than the SS-group. With regard to exploration and free improvisation within the music space clients' participation is referenced from both diagnostic groups. The data indicate growing levels of confidence in musical participation across both diagnostic groups. With exceptions from the SS-group, the MDD-group seemed to present with low confidence and hesitancy, more so than clients from the SS-group. It stands to reason that increased confidence levels were evident in clients from both diagnostic groups, with the higher incidence of references from the MDD-group. With regards to sharing within joint musical interaction, the descriptions indicate that clients from both diagnostic groups engaged in call and response musical interaction and demonstrated the capacity for negotiation and resultant mutual musical moments. With regard to the recall

of musical material or musical moments within the therapeutic process, the data examples refer to clients from both diagnostic groups. This suggests that participation in active music making stimulates recall and make possible learning performing and extending musical material. This theme also described creative elaborations of musical qualities and the data suggest that clients from both diagnostic groups could assume leadership roles, offer independent musical material and extend musical qualities such as melody, rhythm, movement repertoire and creative improvisation.

4.11. Theme 10 – Resolution or arrival

The final theme concerns the maturation or 'arrival' of musical expression. It is at this stage that clients display autonomy and independence in music making, a coming into their own musically. Evident towards the end of the music therapy intervention were aspects of arrival and completion in musical expression in the case of some clients. For other clients there were moments of arrival and resolution juxtaposed with characteristic musical expression such as fragmentation or perseveration. This theme will be discussed with reference to i) holding, ii) musical clarity and iii) resolution.

4.11.1. Holding (AM29, AM30, AM298, AM305, AM306)

'Holding' refers to clients' ability to play independently within joint improvisations. This refers to clients' capacity to hold their own within musical interaction. This is often not easy for clients during the earlier stages of therapy. It is common for clients, for numerous reasons, to become dependent on the musical leadership of the therapist in earlier sessions. In the case of clients who responded more naturally and confidently to music this happened earlier in the process, whilst for others this only happened later in the process.

Examples from the data include: - holds her own musically (A3 5p), carries the rhythm (F3 1i), holds pulse while therapist improvises (H3 5i), first time client holds pulse, counting aloud while therapist plays solo (O7 5a), could hold pulse and play solo section (T7 2c), holds her own when playing off beat (H3 3f), holds rhythm when therapist introduces changes (I4 1h), holds her own when therapist introduces pauses (I8 4i), maintains rhythm when therapist plays something else (Q3 4b), copied therapist less (N3 3g), holds his own playing independent musical material (N3 4e), holds her own musically even when hesitant (O3 6e), plays similar rhythm, holding his own (Q3 5j).

Audio clip 20 (Track 20 – Holding his own)

This audio clip demonstrates a fluid, strong musical exchange between client and therapist wherein the client plays independent musical material within the improvisation and is able to hold his ground musically when the therapist initiates a musical change. Approximately 27 seconds into the clip the therapist begins to play a strong pulse in half time. There is no hesitation from the client as the music changes. He introduces a rhythmic pattern which he holds and the musical interaction resembles a musical groove. This is an example, from the final session, of a *moment* of arrival for Client N. During the course of the eight sessions, Client N mostly copied the musical material of therapist, he had difficulty concentrating and remembering for any length of time and his music was generally perseverative.

4.11.2. Clarity (AM63, AM71)

There were instances in musical participation where the music was described as clear, having greater clarity, more defined or definite. Whilst the data refer to examples of clarity and definition in clients' music from early sessions, e.g. (Voice clear and soft (E8 1y), clear brief phrase F17 1f)), the reporting here will focus on examples from later sessions or examples that suggest progression towards increased clarity in musical expression. Such examples from the data include: - client sings with clear voice (E8 7s), sings clearly during known section (G16 4h), played with greater clarity (S8 6b), develops more defined rhythm (D8 5j), movements more definite (F3 3k), music more defined and higher energy (G7 3h), drumming becomes more energetic with definite rhythm (L5 3c), musical presence more definite (S8 6g), more structured when completing sections of songs framed by therapist (S8 6o), not fragmented exploration of music space but music as coherent whole (T8 5f)

These examples from the data suggest moments of resolution or arrival with regard to vocal, instrumental or movement expression. A shift towards clarity implies that music may have been less clear or defined previously. These examples indicate that active music making facilitated moments of clarity and organization, thus affording clients momentary experiences of coherent musical expression.

4.11.3. Resolution (AM09, AM22, AM198, AM286)

Lack of definition and flow in musical expression, such as is present in music that is fragmented and disorganised, make it difficult to sustain phrasing, establish cadence or breathing points in the musical

sentence, settle into the musical flow or end the phrase with a sense of satisfied resolution. Within the music therapy intervention emphasis was placed on inviting clients to sustain and end phrases, songs and improvisations. For some clients this seemed to come naturally but for others sustaining the flow of a phrase until its natural breath or completion point was difficult.

The data illustrate examples of endings or occurrences within musical interaction which signify completion and flow. These include:- completes musical phrases alone (D17 4e), completes phrases (E17 1j), completes phrases, introduces new musical material with space therapist offers client (T8 5e), silence when music is finished (F14 2i), silently hold music space (H3 4ad), client ends improvisation assertively (D3 5k), anticipates end of piece (D8 2p), ends improvisation in definite manner (E3 4q), ends improvisation with surprise element (F11 2h), initiates ending of improvisation, ends improvisation with sustained vocal note (P8 2r), ends improvisation with strong, sustained note (P8 4q), ends improvisation dramatically (R8 6i), ended improvisation in definite manner (S8 7p).

Whilst aspects of disturbance and difficulty, interrupted flow and irregularity might always be present in the case of some clients' music, the data suggest that moments of resolution or arrival are possible. These moments afford such clients experiences of coherence and completion, albeit in some cases, fleetingly.

4.11.4. **Comparative findings – Theme 10** (Resolution or arrival)

The data suggest that resolution or arrival are experienced in active music making in the form of musical holding, increased musical clarity and definition and through musical endings. The data suggest that such moments of resolution or arrival were experienced and initiated by clients from both diagnostic groups. The data highlights that in some cases resolution is momentarily experienced whilst juxtaposed with musical expression characterised by disturbance, difficulty or irregularity, but nonetheless still afforded through joint musical interaction in the case of clients from both diagnostic groups.

4.12. Two kinds of findings

This chapter has reported on the musical affordances whereas the previous chapter reported on the verbal affordances. Although the two kinds of affordances, verbal and musical, are separated in two chapters, the experiences themselves of clients were not necessarily so separated. The same experience was at times

expressed in both verbal and musical terms, notwithstanding the fragmentations and the incongruences at times reported above. The next chapter will appraise these findings and the methodology from which the finings derived.

Chapter 5: Appraisal of the study

This chapter comprises two sections. Part A appraises the findings pertaining to verbal and musical affordances as detailed in chapters 3 and 4. Part B appraises the methodology governing this study and makes recommendations for further research.

Part A: Appraisal of findings

The aim of this research was to explore the affordances of Active and Receptive Music Therapy techniques separately and in combination, with clients from the MDD and SS diagnostic groups respectively. Central to the music therapy intervention and the analysis of the data was the direct lived experience of the client in therapy, with emphasis placed on what the client had to say through musical and verbal expression.

This appraisal will reflect upon the findings from the music therapy intervention and post therapy in-depth interview with reference to i) emerging client voices, ii) affordances in respect of the respective and joint contribution of the music therapy techniques and iii) implications for practice.

5.1. Introduction

The findings reported in the previous chapters are premised on the deliberate qualitative approach of giving a voice to the subjective and personal experiences of people who may be compromised expressing themselves, in having a (full) voice, so to speak. In stark contrast, at the time of writing this chapter, South Africa is grappling with the well-publicised tragedy of the deaths of more than 94 mental health patients in the province of Gauteng who were denied a voice. The patients at the centre of this incident represent a vulnerable, marginalised sector of South African society who, in addition to suffering the debilitating effects of mental illness, are subject to socio-economic challenges such as unemployment, poverty and inadequate family, social, and community support.

Within this unfolding story is the deafening silence of the voice of the patients themselves. If they did speak, no-one seemingly listened. If they did speak, what they had to say did not truly matter enough to avert their deaths. Ironically, it is the matter of ‘hearing voices’ which constitutes a core component of

the health system's function in the care and treatment of patients with varying mental illness diagnoses. As part of necessary standard care, 'the 'voices' are treated and managed with the effect of silencing their incapacitating impact, but here important voices of mental health users and practitioners were silenced.

Another silencing, even if in part, may result directly from mental illness. This may particularly be in the case of patients for whom the combined impact of dire life circumstances and chronic mental illness is overwhelming and (at least seemingly) unmanageable. These patients find themselves, all too often, at the bottom end of medical care, employment opportunity and social support. In such cases isolation and monotone characterise lived experience, where the perceptions of society perpetuate this solitary journey through imposed labels and assumptions (Rolvsjord (2014).

A mental illness diagnosis, carries with it stigma, isolation and loss, in some instances reducing the individual to the singular phenomenon of 'mental health patient'. The individual is described or referred to through the lens of clinical features, a diagnostic label, a surname or even just a patient number, reinforcing the narrative of the patient as ill, abnormal, weak, pathological and dis-able. This narrative holds the potential to render the patient powerless, voiceless and without agency (van den Tillaart et al, 2009, Rolvsjord 2014).

There are multiple complexities operating here and the intention is not to criticise mental health care systems. The point is instead that we need to account in a scholarly way for the voice of patients, with even more sensitivity when such voice may be compromised by mental illness, stigmatisation, and impoverished circumstances – as will attest many committed, caring and compassionate professionals and volunteers working in the quest to provide the best mental health care possible. Music therapy provides for this sensitive listening, no less so by expanding the scope and means of expression from the verbal to the musical.

Central to an ethnographic study conducted by Biehl & Locke (2010) amongst the urban poor in Brazil and Bosnia–Herzegovia respectively, is the juxtaposition of the plight of powerlessness and marginalisation with the possibility of breaking the impasse. The study was framed by Deleuze's theory on becoming, which holds that through microanalysis we bring into view the immanent fields that people, in all their ambiguity, invent and live by. Such fields of action and significance are mediated by

power and knowledge, but they are also animated by claims to basic rights and desires. He emphasises the primacy of desire over power and believes in the creative capacity of people to 'carve out life chances form things too big, strong and suffocating' (Biehl and Locke, 2010:317, Deleuze, 1997). From the diary entries of Catarina, a female patient in a mental health facility, Biehl & Locke (2010) take her words and what she writes in the dictionary literally and in so doing hears her ongoing, wrenching struggle to become, to exceed and escape her diagnoses, to develop relations of desire and care with others.

The participants in the research on which I report in this thesis fall very much within the description of the patients referred to at the beginning of this chapter. They are the vulnerable ones, the 'Catarina's', those isolated from family and society, with inadequate economic and social support access, those who may very well have lost their voice somewhere along the way.

Biehl and Locke (2010) suggest "It is time to attribute to the people we study the kinds of complexities we acknowledge in ourselves, and to bring these complexities into the forms of knowledge we produce and circulate. For in learning to know people, with care and an "empirical lantern" (Hirschman, 1971) we have a responsibility to think of life in terms of both limits and crossroads—where new intersections of technology, interpersonal relations, desire, and imagination can sometimes, against all odds, propel unexpected futures" (Biehl and Locke, 2010: 318)

5.2. Emerging voices

Upon the close inspection of the study on which I report here, the clients had much to say both verbally and musically. Examination of the three sets of themes, as situated side by side in Table 5.1, provides an overview of these verbal and musical utterances. From the three sets of themes, the composite voice of the client is heard as expressed through eleven salient aspects articulated as 'emerging voices', i.e. i) the voice of struggle, ii) the voice of disturbance, iii) the voice that feels, iv) the voice that desires, v) the voice of isolation, vi) the powerless voice, vii) the voice of flow and connection, viii) the reflecting voice, ix) the symbolic voice, x) the resilient voice and xi) the voice of liberation. These emergent voices, so to speak, are interpretative composites of the similarities that pertain among the themes. The extent and nuances of the emerging voices will be discussed in summary with reference to the themes presented in chapters 3 and 4 as reflected in table 5.1.

Table 5.1. Summary of themes

Themes: Verbal affordances (VAT)	**Themes: Musical affordances (MAT)**	**Themes: Post therapy process in-depth interview (IntT)**
Not to feel	Reciprocal responding	Praising the impact of music therapy
To do or not to do	Explicit use of symbols through music	Gaining perspective
Grappling with the desired future	Regularity	Taken up within own experience
Hurt and fear of undesirable outcomes	Disturbing and difficulty	Creatively inspired and energised for the future
Sadness, brokenness and futility	Turning points	Coming to joy and peace
Anger, trust and vulnerability	Energy bursting and lacking	Liberation – to do and from frustration
Desire for connection and affection of others	Bodily synchrony	Upbuilding and filling
Barricaded from being present, now	Intensified emotional expression	Closer and improved interaction
Tensing and un-tensing	Exploring new territory	Opening up and emotionally dealing with old wounds
Relating to one's musical expression	Resolution or arrival	Grappling with and to change
Reflections on the music and music making in therapy		Strengthening more than anticipated
Resilience in courage		Unease in and before therapy
Invigoration and liberation		

5.2.1. The voice of struggle (VAT1, VAT3, VAT4, VAT5, VAT9)

Not being able to feel, feelings of indifference, suppressing unbearable feelings and being afraid of feeling and facing emotions were all articulations of the voice of struggle. Struggle was also voiced through references to suicidal ideation, doubts and skepticism about facing a dreaded future and experiencing impasse. Reality is deemed as hardship and struggle and described as 'the worst journey to

be endured'. This voice indicated a desire to escape an unbearable reality to an idealised situation. The disabling impact of trauma, fear of ongoing hurt, pain and fearing an unknown future perceived as ominous are all expressions of struggle. Furthermore, the struggle is embodied through indications of bodily distress, tiredness and feelings of stress and tension.

5.2.2. The voice of disturbance (IntT 12, VAT2, VAT8, MAT4, MAT6, MAT7)

The voice of disturbance was expressed both verbally and musically. When reflecting on the music therapy process in the post therapy in- depth interview, clients reported on being in an impaired state prior to music therapy. Experiencing improvisation as disturbing and uneasing was reported. Clients articulated difficulty concentrating, being present in the here and now, and experiencing memory difficulties. Furthermore, in musical participation clients expressed feelings of being stuck or blocked, as well as low levels of self- confidence which limited accessing and expressing new musical ideas. Irregularity, interrupted flow and limited variation and range of expression were present in music making. Disturbance was also evident in the incongruence between affect and musical expression, practical and technical difficulties with regard to active music making as well as the evidence of rigidity and perseveration in musical expression. Finally, low energy levels, blunted affect, lethargy, the presence of tremors, stiffness of body and moving unnaturally may indicate disturbance expressed in physical function.

5.2.3. The voice that feels (VAT5, VAT6, MAT8)

Emotional expression is integral to all forms of expression and can, therefore, not be separated out from any of the voices described in this chapter. This voice is singled out though, as it articulates a deepening of emotional expression and reference to specific internal feeling states.

Through verbal responses feelings of sadness, being heartbroken, feeling smashed and broken as well as feelings of hopelessness and experiencing the self as useless were articulated by clients. Furthermore, feelings of vulnerability, anger towards self and others as well as difficulty trusting others were expressed. Weeping occurred during active music making and intensified emotional expression was sounded through musical dynamics and sentiments expressed through varied qualities of musical expression.

5.2.4. The voice that desires

This voice articulated personal desires such as desire for independence, for financial independence, to be with family and for family relations to be restored. Desire for romantic love and social connection was expressed. To access one's inner voice, freedom, growth, happiness, to live and to live with increased energy are all desires iterated through this voice.

5.2.5. The voice of isolation (MAT1, VAT7)

Through musical participation the voice of isolation was expressed through limited 'in the moment' awareness and difficulty engaging within the musical relationship, as evidenced by the vacant stare, averted gaze, blunted affect and low levels of self – confidence all preventing clients from venturing towards interactive musical experiences. Through verbal expression this voice lamented loneliness, isolation, being away from family and social networks. Feelings of rejection, loss, 'being alone with my problems' and experiences of neglect were expressed.

5.2.6. The powerless voice (VAT 2, VAT5, VAT9, MAT4)

Powerlessness was expressed through references to being emotionally stuck, not being able to change circumstances, being at the mercy of the decisions of individuals and systems, limited opportunities due to economic and education status, the impasse experienced from being dependent on others, not being able to change one's response to the debilitating effects of trauma, perceiving the self as weak or useless and limited belief in one's own capacity to be creative or contribute to musical participation.

5.2.7. The voice of flow and connection (IntT8, VAT7, MAT1, MAT3, MAT7, MAT10)

This voice was expressed, in active music making, through experiences of regularity, flow, stability, expressive and natural movement, increased engagement, reciprocal responding and experiences of holding and resolution through supportive, interactive musical expression.

Verbal responses expressed the desire of and need for social support and human connection as well as indicating the value of being able to share personally within the music space.

Verbal reflections indicated that music therapy establishes togetherness, connection and improved

interaction.

5.2.8. The reflecting voice (IntT1, IntT2, IntT3, Int9, IntT10, VAT10, VAT11)

Reflections on aspects of the lived experience of music therapy include spontaneous commentary on active music making, making choices in music making, reporting on never having made music before and reflecting on reconnecting with music through personal associations. The voice of reflection was also heard through the post therapy in-depth interviews. Here clients reflected on music focusing the mind, being in touch with emotions, being exposed to new experiences and gaining new self- realisations. This voice shared on how perspectives were gained and changed, how connections were made between past, present and future and how an awareness of spirituality was renewed. Clients reflected on how music elicited memories and how music opened up and facilitated dealing with old wounds. Summing up the music therapy process one client stated: “Wanted feelings in and unwanted feelings out”. Reflections also included statements concerning the impact of music, music as an essence of being and the uniqueness of music therapy, aspects of music therapy process which were experienced as frustrating and not enjoyable.

5.2.9. The symbolic voice (VAT 11.4, MAT 2)

This voice spoke metaphorically using images, associations, symbols, memories, feeling states and musical experiences. The symbolic material assisted clients in examining, exploring and sharing their story. The metaphors ranged from concrete associations with people and objects to images and symbols of an abstract nature.

5.2.10. The resilient voice (IntT7, IntT11, VAT2, VAT12)

This voice grew clearer as the music therapy process developed. “Stronger than the pain’ is a statement of resilience. Resilience was expressed through statements of acceptance of circumstances, being open to change and moving forward, increased motivation for goal setting, references to strength and courage, intention to persist forward, willingness to venture and make decisions and attributing positive qualities to the self. Through the in-depth interviews clients reported having experienced music therapy as up-building and filling, strengthening, promoting self-growth and increasing self-confidence.

5.2.11. The voice of liberation (IntT5, IntT6, MAT5, MAT6, MAT9, VAT9)

The voice of liberation was primarily sounded through active musical participation. Movement towards liberation was experienced through extending and varying the range of musical expression, a shift from low to higher affective and musical energy states, and articulations of music calming stress and tension. Liberation was voiced through spontaneous musical initiative, interactive musical thrill and mutuality, increasing exploration in music making, increased self-confidence in musical expression, developing musical material based on clients' recall of musical material from previous sessions and the creative elaboration of musical qualities.

Clients reported, during the in-depth interviews, of experiences of enjoyment and laughter, peaceful comforting, feeling better, expressing frustration, being rid of anger and irritation and allowing the self to be free.

The verbal and musical affordances, as presented in chapters 3 and 4, and the emerging voices as described above are reflected through a *sonic prism* of verbal and musical utterances resulting from the contribution of the diagnostic group responses and the music therapy techniques respectively and in combination. The diagnostic groups and music therapy techniques can be likened to orchestral instrumentation or expressive scaffolding through which a textured sonicscape of music and words was created, allowing the voices to emerge and supporting them as they performed. In considering the respective role of the diagnostic groups and the music therapy techniques in the emergence of affordances and voices, section 5.3 considers similarities and differences of verbal and musical expression within and between diagnostic groups and section 5.4 appraises the contribution of the music therapy techniques respectively and in combination.

5.3. Speaking and listening

Twenty individual participant voices comprise the emerging voices presented in 5.2. Each voice spoke uniquely through musical and verbal expression and each client engaged with the components of the music therapy intervention distinctly. The voices express the lived experience of personal story as well as the journey with mental illness.

It is not always easy for these clients to speak, but at no stage do the clients not speak in the broadest sense. Verbally, non-verbally and musically clients speak. Emotional, physiological, cognitive and psychological factors may play a role with regard to limitations and difficulty within verbal and musical expression but in spite of these, clients give expression to who they are (Ansdell, 1995; Pavlicevic, 1997).

The primacy of individual response is, therefore, upheld within this reflection and it is not the intention for the individual voice to be lost when considering how the voices speak when comparing clients within diagnostic groups as well as between diagnostic groups.

Most noteworthy was the higher degree of homogeneity in verbal and musical participation amongst the participants within the MDD-group than within the SS-group. In the MDD-group the verbal and musical expressions of all clients indicated low mood and energy and expressed feelings of hopelessness and futility. All clients were able to engage with music in an abstract manner and work with symbolic material and all clients were able to articulate inner feeling states, aspirations and difficulties to a greater or lesser extent. In general the musical expression of the MDD-group was congruent with low affect, energy and motivation levels in the beginning stages of therapy with most clients extending their range of musical participation and using the music in a symbolic and embodied manner in order to give another voice to their personal process. Common to all clients within the MDD-group was the divide which seemed to exist between the hopelessness and impasse of the lived experience of major depression and the desire to escape to an idealised place.

Within the SS-group there was less homogeneity amongst group members as expressed verbally and musically. For some clients verbal and musical expression was difficult or limited – either due to language constraints or due to difficulties with the articulation of thoughts and feelings or, in the case of musical expression, disorganisation, rigidity or perseveration. Other clients in the SS-group, however, found verbal expression easier. Still, within this group of SS-clients, though, there were differences in response demonstrated in disorganised speech and musical expression, rigid thought patterns evident verbally and musically, limited insight into illness, difficulty expressing feelings and limited capacity for self–reflection. Engagement with Receptive Music Therapy techniques resulted in some clients working with symbolic material at an abstract level within the realm of their lived experience whereas for others the engagement with symbols was at a more concrete level which is reflected upon later in this chapter. The area of greatest homogeneity within the SS-group was the difficulty experienced by all clients with

regard to articulating emotions, to a greater or lesser extent.

Clients from both diagnostic groups experienced heightened energy levels, articulated experiences of pleasure in music making and engaged in spontaneous musical and verbal self-expression, reflecting experiences of liberation, creativity, turning points and personal benefit to a greater or lesser extent.

When comparing the voices between diagnostic groups three primary differences emerge. Firstly, clients within the MDD-group could more readily access emotions and articulate specific feeling states whereas clients in the SS-group experienced difficulty accessing and naming feelings. Being heard and understood is compromised when one is not able to articulate a thought or feeling. Secondly, clients in the MDD-group were able to more readily reflect on the words, music and symbols within the music therapy process from session to session, as well as over time, whereas the clients in the SS-group worked more in the immediacy of the moment through verbal and musical expression. This may also compromise speaking and being heard when continuity of thought and process is not easily accessible for the clients in the SS-group. Thirdly, clients in the MDD-group seemed more able to articulate specific desires or actions towards envisaging a future or recovery (even when this seemed remote or hard to attain in the face of difficulty), whereas clients from the SS-group seemed to articulate aspirations disconnected from a sense of practical application to concrete, daily life.

A special kind of listening is required to hear the voices of these clients. It is difficult to really listen to a voice which is, inter alia, limited in its capacity to express, disorganised, rigid, devoid of emotion and unable to articulate what lies within. If we rely solely on verbal information, we may not easily hear what it is the client has to say. Also, if we are listening in order to make sense, as the therapist, of a client's experience we may not fully hear. When we extend the client's voice beyond the verbal to the musical and non-verbal and listen in a more nuanced manner to the *what* and *how* of the voice, and when we listen to how the *client* makes sense of their experience, perhaps then listening would lead to attending to and really hearing what it is patients have to say and need us to hear.

Lipari (2010) suggests that in listening we become and that to truly hear the other that a stance of 'listening being' should be adopted.

> "Listening is thus a dwelling place from where we offer our ethical response, our hospitality, to the other and the world. Listening being is thus an invitation—a hosting. This hosting of other is

> as a guest, as a not-me. I don't have to understand, although you may feel ''understood. 'I don't have to translate your words into familiar categories or ideas. I don't have to ''feel'' what you feel, or ''know'' what it feels like to be you. What I do need to do is stand in proximity to your pain. To stand with you, right next to you, and to belong to you, fully present to the ongoing expression of you. Letting go of my ideas about who you are, who I am, what ''should'' be. I let all that go, and stay present, attending, and aware. Not indifferent, but in a state of letting go of conceptual thought, what Levinas calls beyond dialog, and what Heidegger calls releasement" (Lipari, 2010: 351).

Perhaps listening in this way affords the experience of another finding their voice, of coming into their own through being heard by another. This mode of listening opens up the listening act to possibilities of hearing what may not normally be heard. We listen to the music, the verbal, the non -verbal, the symbols and the silences through which our clients speak. Perhaps it in the mode of listening that the voice of the client has space to emerge.

The following section reflects on the role of the respective music therapy techniques in respect of verbal and musical expression.

5.4. Contribution of music therapy techniques

The themes, detailing the verbal and musical affordances, referred to in chapters 3 and 4, and the emerging voices presented in this chapter arose from clients' appropriation of Active and Receptive Music Therapy techniques as unique for each individual's personal music therapy process. De Nora (2000) clarifies such appropriation as interdependent on affordance. Music is both acted with and upon. As music 'users' appropriate music by responding to it and incorporating it into their actions so they are afforded what music makes possible for them in that situation. Music's role as a health technology depends, therefore, on how it is appropriated and on what it affords through this process (De Nora, 2007: 276). It is, further emphasised that music's affordances are experienced in and through active practices of listening and or otherwise appropriating music, such as active musical participation (De Nora 2007). Drawing from the comparative findings in chapters 3 and 4, this section presents the contribution of the music therapy techniques, respectively and in combination, to the verbal and musical affordances.

5.4.1. Contribution of Receptive Music Therapy techniques

Chapter 3 reported on the verbal affordances as arising from responses to both Active and Receptive Music Therapy techniques. Upon closer inspection, the respective music therapy techniques gave rise to distinct affordances. This section reflects on the various affordances brought about by the range of Receptive Music Therapy employed during the music therapy intervention. The subheadings below express the similarities across themes as contributed by the Receptive Music Therapy techniques.

5.4.1.1. Eliciting and voicing internal feeling states

Through the combined creative act of music listening, imagery, symbols, visual art processes and verbal reflection a range of feeling states were elicited. These feeling states ranged from indifference and emptiness, to deeply painful and unmanageable emotions, across the spectrum to emotions of joy and hope. Clients reported that music listening techniques helped with expressing emotion. Receptive Music Therapy techniques exclusively gave rise to the themes which dealt with feelings of, inter alia, sadness, brokenness, anger and vulnerability.

5.4.1.2. Telling of personal story

Through the awareness of emotions, recalling life-event memories and working with symbolic material personal narratives from past and present were shared.

5.4.1.3. Self as social being

Feelings of isolation, loss of social relationships, being away from family members and an awareness of the need for social connection were elicited through Receptive Music Therapy techniques.

5.4.1.4. Self- awareness

As clients identified feelings, related personal stories and reflected on their experiences in music therapy, so self-awareness was heightened. Examples include: awareness of the fear of facing feelings, connections between past and present and discovering/rediscovering parts of self.

5.4.1.5. Desire

In the presence of indifference, blunted affect and the stagnation of self -expression, Receptive Music Therapy techniques elicited desire. Expressed desires include being at peace, personal and financial independence and a longing for romantic love. This is noteworthy because living with a mental illness can result in self-dismissal, lack of self-care and ongoing loss of personal aspirations. Articulating desire, thus, implies a reconnection with the self and a tapping into what the self may need and wish for.

5.4.1.6. Increased internal motivation

Features such as indifference, low motivation, emotional and psychological impasse and low energy were present, in varying forms, in all music therapy sessions. Within this context, Receptive Music Therapy techniques invited clients to broaden perspectives, explore new possibilities, envisage a future and access inner personal resources. Client responses indicate increasing internal motivation to move forward.

5.4.1.7. Activation to action

For some clients, increased levels of internal motivation led to statements of intention with regard to practical goals and steps towards an envisaged future. Symbolic material, aspects of clients' stories and statement of intentions were linked, wherever possible, to concrete, daily life in order to assist the client in planning and articulating reachable goals. For some clients that meant thinking about how to resume work related responsibilities, whereas for others it may have related to the minutia of day to day functioning such as thinking of how to differently manage the first half of hour of each day.

5.4.2. Contribution of Active Music Therapy techniques

As stated during the introduction to this chapter, music therapy provides for a broader range of expressive possibilities and creates an environment for sensitive listening, through expanding the scope and means of expression from the verbal to the musical. Chapter 3 reported on verbal responses to both Active and Receptive Music Therapy techniques and chapter 4 on the musical affordances emerging from the Active Music Therapy component of the music therapy intervention. The subheadings below

express the similarities across themes as contributed by the Active Music Therapy techniques.

5.4.2.1. Appropriation of music for personal expression

Clients appropriated Active Music Therapy techniques to give expression to their personal process during the music therapy intervention. Clinical improvisation was appropriated to reflect and express emotional and symbolic material elicited by Receptive Music Therapy. Song writing is another example of an Active Music Therapy technique appropriated by clients to express a sentiment about significant others, or as a telling as part of their story.

5.4.2.2. Embodiment

Active Music Therapy afforded the musical embodiment of feelings, thoughts, intentions and aspects of personal story through musical expression and movement. This happened in three ways: i) words either informed or followed musical expression, ii) music took over when words failed, iii) music happened without words.

5.4.2.3. Being active

Relaxation, movement and various forms of music making comprised the Active Music Therapy component. This affordance is expressed through references to the benefit of exercise, the enjoyment of dance, the alleviation of boredom, heightened energy levels and the stimulation brought about by active musical participation.

5.4.2.4. Calling to focus

Whether due to being shut down by unbearable emotions, numbed by the effects of medication or disoriented due to the impact of psychosis, music was able to redirect focus to the present moment within the context of interactive music making. Here structured musical exercises as well as improvisation were employed to engage clients directly, affording experiences of structure, coherence and connection.

5.4.2.5. Agency

Active Music Therapy afforded clients the opportunity to exercise choice and leadership in music making. Influence, control, initiative, preference and refusal were aspects of expressed agency. Some clients experienced difficulty accessing and initiating musical material ideas and were reticent to exercise choice. Such clients required regular invitation and encouragement to exercise personal choice. The musical contributions or refusals of clients who were less inhibited, openly eager or resistive were non- judgmentally accepted.

5.4.2.6. Relationship

The client-therapist relationship is the container in which active musical participation occurs. Music making occurs jointly and experiences of reciprocity, mutuality, co-creativity and support are afforded. This is a noteworthy affordance considering social withdrawal and isolation experienced by individuals with a mental health diagnosis.

5.4.2.7. Spontaneity and creativity

Against the backdrop of the challenges of mental illness, most especially trans-diagnostic negative symptoms, Active Music Therapy afforded spontaneous music making through which heightened energy levels, access to inner creativity and joyfulness were experienced.

5.4.2.8. Recreation

Active Music Therapy afforded experiences of fun, pleasure and enjoyment. The recreational benefit of musical participation is seen within the context of the hospital routine described as monotonous, boring and under-stimulating. Apart from therapeutic benefit, music therapy sessions may have been deemed a welcome break in a monotone existence and seen as ‘something to do’. This may account for the relatively low dropout rate in the study as only two clients withdrew participation after the first session, whilst the remaining participants attended all sessions, or participation was only terminated due to discharge or further treatment reasons.

5.4.2.9. Stress release

Stress release was experienced primarily through drumming, songwriting, relaxation exercises and movement. Clients experiencing anxiety, nervousness or stress were afforded cathartic experiences through the physical act of musical and movement participation.

5.4.3. Joint contribution of Active and Receptive Music Therapy techniques

Whilst chapters 3 and 4 detail distinctive verbal and musical affordances of Active and Receptive Music Therapy techniques respectively, it is also important to emphasise the interdependence of the two approaches. The joint contribution of Active and Receptive Music Therapy techniques offer the space for various forms of response and self –expression to emerge through, inter alia, music listening, active music making, verbal processing, silences, symbols and images within the context of a co-creative therapeutic relationship. The joint contribution of the music therapy techniques are expressed interpretatively, by virtue of similarities, by the subheadngs below:

5.4.3.1. Revealing impasse and difficulty

In Active Music Therapy impasse and difficulty were experienced in the form of musical irregularity, perseveration, rigidity, fragmentation, disorganization, anxiety and performing music within a limited expressive range. In Receptive Music Therapy impasse was revealed through references to anxiety, ‘stuckness’, feeling powerless to control or change circumstances, being dependent on others. This is considered an affordance as this reveals the client’s lived reality, it is the place in which therapy takes place, and from which development or change may be possible.

5.4.3.2. Unconscious material and different aspects of the self

Both Active and Receptive Music Therapy techniques facilitated memories, associations, aspects of personal stories and feelings to surface. Using the techniques in combination allowed clients to verbally reflect on what was being elicited during Receptive Music Therapy techniques and musically embody and integrate insights, thoughts and feelings through clinical improvisation and songwriting.

5.4.3.3. Heightened experience of the music

Clients increasingly connected to the music in different ways. Music was recognised, listened to in new ways, heard concretely and symbolically, appreciated, remembered, experimented with, associated with difficult and helpful memories, became an ally and was recognised for its benefits in the moment.

5.4.3.4. The language of symbol and metaphor

The combined creative act of music listening, visual art processes, movement, verbal reflection and musical improvisation invited the clients to give voice to feelings, their story and their experiences in the form of verbal and non-verbal symbol and metaphor. At times the symbol could be articulated and reflected upon and at other times the music became the symbol which did not always require words.

5.4.3.5. Shifts

Statements such as “Stronger than the pain”, “the music will help me to gently untie”, “decimal breaking the barrier” and “at the crossroads – no left turn” and references to feeling alive, liberated and wanting to live are indications of personal and emotional shifts brought about by the music therapy process. It is important to note that this happened when clients’ actively engaged with the range of music therapy techniques and worked hard within sessions as collaborators in the process. Turning points and shifts specific to active music making occurred through experiences of regularity, flow, variation and adapting to and extending musical material, which was often in stark contrast to characteristic forms of musical expression.

5.4.3.6. Inner strengthening

The combined creative act offered a space for clients to access stronger, healthier parts of self. Sounding and creating music which represented courageous, fearless or able parts of self, or reflecting on a symbol which was connected to possibility and hope afforded clients a space from which to consider alternatives and through which to experience themselves in ways other than the labelled ‘mentally ill patient’.

5.4.3.7. Experiencing vitality

Within the lived experience of negative symptoms ever present in the music therapy sessions were moments of vitality elicited through Receptive Music Therapy techniques in the form of experiences and symbolic material which resonated life, and through Active Music Therapy in the form of spontaneous, creative, energetic improvisation, drumming and movement. Evidence of vitality was more present in the later sessions as musical engagement seemed more sustained over time.

5.4.3.8. Relaxation and calming

Most clients approached music therapy with nervousness, understandably being unsure about the novelty of the experience. More than that, stress and anxiety seemed synonymous with the experience of most participants. References to feeling relaxed, music calming sadness, experiencing the music as soothing, and feeling peaceful were in response to music listening, the relaxation component, drumming and improvisation which indicate the joint role of receptive and Active Music Therapy in this affordance.

The affordances described above are supported by Ansdell (2014) who suggests that music offers i) a social experience in the form of musical togetherness, ii) generosity, through welcoming a client in, and creatively working to meet the client in every present moment, iii) belonging, as acquired 'through musical engagement and attunement, which opens up new spaces for an intimate communication supporting culturally based personal styles of 'being together in time' (Gratier and Apter-Danon, 2009: 304), iv) experiences of interactive ritual which transforms personal and social experiences, v) moments of epiphany through which access to what may seem inaccessible is made possible, vi) musical thresholds which call for a crossing over or through to new territory. At the point of threshold ambivalence or impasse may be present with choices as to whether 'we enter, retreat, hesitate, linger or dance' (Ansdell, 2014:265), vii) musical hope which helps us to think of the relationship between past, present and future. Zuckerkandl's (1956) refers to the image of the *sonic saddle* on which we can ride the fullness of the present musical moment and suggests that "to hear music is to be flowing with time; is to know the past and the future only as characteristics of the flowing present, as its two directions away from and toward" (Zuckerkandl, 1956: 152). Ansdell (2014) further suggests that musical time challenges the notion of human time and alternatively provides an audible understanding of the possibilities of human time as being "alive, connected, habitable, purposeful and transcendant" (Ansdell,

2014:278) and vii) musical flourishing whereby, through music, experiences of wellness and wellbeing can be experienced within illness and difficulty.

5.5. Implications for practice

The emerging voices and affordances from this research study suggest that Active and Receptive Music Therapy techniques employed respectively and in combination contribute robustly to clinical practice in adult mental health, with respect to the diagnostic groups represented in this study. Combining music making, music listening, verbal processing, other modalities such as visual art processes, movement and relaxation opens up a space for new possibilities of communication, collaboration, creativity, shifts in mood, energy and affect states, increased motivation levels and focused 'here and now' experiences. Within this potential space the person and voice of the client can emerge and be seen, heard and fully engaged with.

The following section reflects on the implications of the findings on clinical practice. The implications consider i) the potential offered to the therapy space of the interdependence of active and music therapy techniques; ii) holding complexity; iii) symbols and story –diagnostic implicatios; iv) integrating the split voice and v) activating the voice of agency. The section is completed with an example from the case work illustrating salient aspects of the findings.

5.5.1. Therapeutic potential within the interdependence of Active and Receptive Music Therapy techniques

As indicated in the previous section, Active and Receptive Music Therapy techniques respectively, and in combination, contribute in varied ways to a music therapy process. Through active music participation the voice of the client is sounded through interactive music making with the therapist, whether thoughts, feelings or reflections have been formulated and articulated or not, whether verbal expression is accessible or not and whether the music is conventionally understood or not. Active musical expression is a realm within itself of sonic emotional expression and communication. Receptive Music Therapy, on the other hand, affords the formulation and articulation of thoughts, feelings and reflections based on imagery, symbols, feelings and associations elicited by music. This is not to say that within Active Music Therapy words, symbols, thoughts and feelings are not formulated and articulated,

but rather to make the point that Active Music Therapy can facilitate a purely musical expression of self and that, within the context of a therapeutic relationship, offers communication, self expressive and growth potential for the client where words may be inaccessible or deemed not necessary. (Ansdell, 1995; Pavlicevic, 1997; Smeijsters).

Smeijsters (2012) refers to the theory of analogy and metaphor as two perspectives from which to explain different music therapy experiences or describe the same music therapy experiences from a different angle. Analogy refers to felt knowledge and embodied cognition with regard to feeling, acting and thinking. Before the individual articulates experience in thoughts and words it is first developed within them in the form of embodied experience. How a person feels, acts and thinks can be expressed in music. Metaphor refers to the connection between the music and the emotion. Metaphors assist in understanding the emotion through what is experienced through the music in the body. (Smeijsters, 2012:) Whilst this theory of analogy and metaphor refers specifically to clinical improvisation, I extend this thinking to include what Receptive Music Therapy may offer. The combination of Active and Receptive Music Therapy seem to offer both experiences. Improvisation facilitates felt and embodied experience most especially when words are absent or premature, or before thoughts are formulated. "The basic idea of analogy in music therapy is that the client's musical processes in music therapy are analogies of his/her psychic processes, that there is an equivalence between the form of the musical expression and the form of the inner experience, be it the way in which the client feels, thinks, or acts" (Smeijsters, 2012: 232).

Receptive Music Therapy offers space for metaphoric work, verbal reflection and the formulation of thought processes which can then be sounded and expressed, in turn, symbolically through clinical improvisation.

It is important to state that, where appropriate, one or the other technique may be called upon to exclusively serve an aspect of a client's process, e.g., Active Music Therapy in the form of structured musical exercises and improvisation may be employed for a client in an acute psychotic phase. In such a case Receptive Music Therapy may not be indicated at all, or perhaps only once the client is more stable. The combined offering of Active and Receptive Music Therapy finds its efficacy and potential in their symbiotic relationship through which the respective techniques inform and support each other. Whilst a standard session plan was designed for each of the eight sessions across all participants (Chapter 2.5),

each client's process was unique in that music therapy techniques were adapted separately or in combination in relation to the response of each client.

5.5.2. Holding complexity

The themes reported on in chapters 3 and 4 refer to data which illustrate the complex milieu in which music therapy happens. This milieu comprises varying expressions of regularity - regularity, despair-hope, interruption - flow, instability – stability, low energy-high energy, pathology –health, sadness-joy, synchrony-dissynchrony, harmony-dissonance, death-life, and disorientation-focus. Desynchronization, loss of affective resonance, impasse, being trapped, rigidity and lost capacity for modulation are apt descriptors of the complexities facing the lived experiences of clients.

Deleuze (1997) states "We don't write with our neuroses. Neuroses or psychoses are not passages of life, but states into which we fall when the process is interrupted, blocked, or plugged up. Illness is not a process but a stopping of the process" (Deleuze 1997:3) He holds that symptoms express a desire or life force trapped and twisted at an impasse awaiting a chance to break through (Biehl and Locke, 2010:332) Fuchs (2001) describes in qualitative phenomenological terms depression as being a desynchronization, expressing the uncoupling of the resonance and synchrony of individual and environment. Uncompleted tasks, trauma, loss, guilt, separation and grief interrupt time and can render the individual trapped in the past with temporary loss of lived synchrony with others and the environment. He states "moreover the depressive suffers the loss of sympathetic resonance; he gets out of synch. While dialogues are normally accompanied by a continuous synchronization of bodily gestures and gazes, his expression sets and loses modulation. The affect attunement with others fails. This is connected to the inability to participate emotionally in other persons or things, to be attracted or affected by them. Painfully, the patient experiences his rigidity in contrast to the movements of life going on in his environment" (Fuchs, 2001: 183).

Also indicated through the data is how the respective music therapy techniques afforded experiences of freeing the trapped life force, igniting capacity for affective resonance, shifting impasse and providing moments of synchronization. Music therapy seems to offer a space in which affect modulation is possible and "seems to be able to take the dysregulated person from somewhere, to somewhere better – to a more homeodynamic state, through which 'the motives and feelings of the human mind are

engaged and transformed" (Ansdell et al. 2010, 23; Trevarthen and Malloch, 2000:5). Metzner (1999) suggests that music therapy offers an unobtrusive presence for a person, who is living in an instable state concerning the differentiation between an inner and an outer world, to find his/her own structures for encountering self and the world.

These moments of modulation and break through take place within the full extent of what the client brings to therapy. It is necessary to hold in tension, then, that these moments of change are only possible when complexities are held, heard, acknowledged and worked with, before too readily redirecting the client towards new territory.

5.5.3. Symbols and story: diagnostic implications

Guided Imagery and Music (BMGIM) is usually contraindicated for clients on the schizophrenia-spectrum due to difficulties such clients may experience with regard to working with imagery and abstract processing (Bonny,2002; Grocke and Wigram, 2007). Whilst this may hold true for the full Bonny Method GIM session format, it does not necessarily hold true for adapted receptive techniques. This study demonstrates that clients from both diagnostic groups engaged with Receptive Music Therapy techniques and symbolic material. In general clients from the MDD-group worked with symbolic material in a more abstract manner than did clients from the Schizophrenia-spectrum group, but this was not exclusively so. In fact, some clients in the SS-group worked intuitively and symbolically through music improvisation and music listening and engaged with symbolic material in an abstract manner (see Images 5.1 and 5.2).

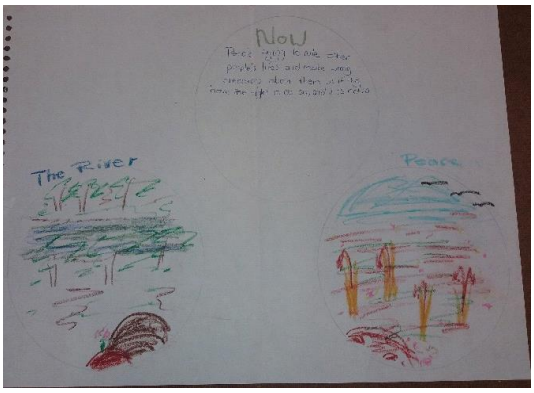

Image 5.1: Client R (SS-group)

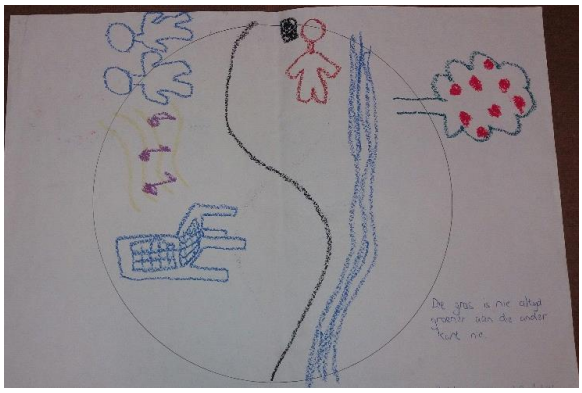

Image 5.2: Client T (SS-group)

With that said, clients from the SS-group tended to work more with concrete symbols, associating objects and known people with music listening processes. What is noteworthy, though, is that whether clients engaged with music listening techniques at an abstract or more concrete level, this always opened the doorway to personal narrative and association.

Included in the music therapy intervention were receptive techniques designed as 2 or 3 step processes (e,g. the three circles technique – where a sequence of three pieces of music were played, combined with visual art process). Whilst the majority of clients from the MDD-group and some from the SS-group could work with these techniques, there were clients from the SS-group, in particular, who experienced difficulty sustaining continuity within the sequence. Of importance, though, is that whether the sequence was followed as per the planned structure or not, these techniques nonetheless afforded the opportunity for connection with one's personal story or significant aspects of self.

The question is, thus, not whether these techniques are appropriate for clients such as those on the Schizophrenia-spectrum, but rather ***how*** these techniques are facilitated in order to meet the needs and responses of clients in the moment. Unkefer and Thaut (2005) state that no matter how symbolic meaning is derived, it gives music communicative potential in a therapeutic setting. Engagement with symbolic expression gives rise to individual meaning which may enable the client to transcend suffering or gain new perspective. Symbols deal with universal problems such as life, love and suffering (Kreitler and Kreitler, 1972: 323-324). Providing an alternate means of personally accessing these themes holds value in clinical work

The data indicate that capacity to engage with symbolic work developed over time with respect to clients, from both diagnostic groups. For example client Q (SS-group) drew child- like objects, (concrete music associations and objects associated with his school days) in response to the first music listening technique in session 1 (Image 5.3), whereas in session 7 (Image 5.4), in a 3-step process he associated the music with i) a childhood memory of his brother, ii) his current stay at the hospital and iii) future desires for a life partner (which had been stated in a previous session).

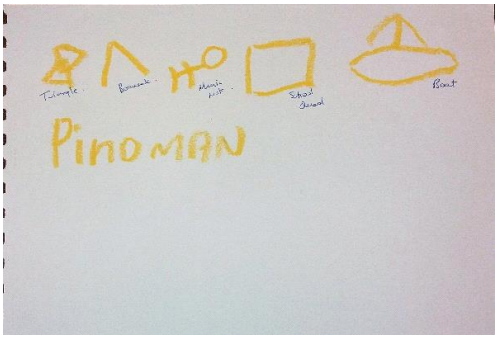

Image 5.3: Client Q (SS) Session 1

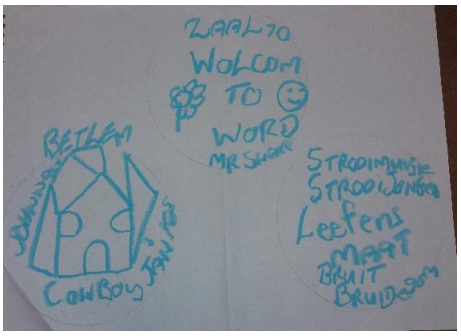

Image 5.4: Client Q (SS) Session 7

This begs the question as to whether abstract engagement with symbolic material only has to do with the cognitive capacity, or whether the impact of mental illness combined with the numbing effects of medication and living for extended periods in under-stimulating environments result in cognitive stagnation. Perhaps working with clients in such settings on a regular basis employing multi-sensory modalities such as music, drawing, clay, stories and verbal reflection might stimulate and develop increased cognitive and emotional capacity over time?

5.5.4. Integrating the split voice

Clients, primarily from the major depressive disorder group, and to a lesser extent those in the schizophrenia-spectrum group articulated being overwhelmed by their struggle with mental illness and personal circumstances. Feelings of 'stuckness' and being trapped were iterated. Juxtaposed with this were expressed desires to escape from the unbearable to an ideal state. The space between lived unbearable reality and the envisaged ideal is where the client seems to experience impasse. And it is from the impasse that the client speaks with a split voice. The split voice indicates the chasm between perceived reality and the envisaged ideal.

Redirecting the client towards their expressed ideal, too soon, is perhaps not therapeutically wise nor serving the client's best interest. The gap between present reality and the envisaged ideal may be too wide, may be too unrealistic to attain. The impasse and split is likely to be reinforced. When modalities such as music, visual arts and movement are employed, as much as they hold transformative possibilities (Amir, 1992; Fachner, 2014; Grocke, 1999b; Odell-Miller, 2002; Pedersen, 1999; Ruud, 1998) these can facilitate lofty experiences which are far removed from lived experience. The balance required is that these moments within sessions which offer the client catharsis, new perspective, and heightened

levels of engagement, hope and increased motivation are to be rooted within the client's lived experience and their personal therapy terrain.

The example of 'the barrier' in the case of Client I's process, (Chapter 4, Theme 2) provides an example of this. Through a Receptive Music Therapy technique, the client formed a clay image, representing a barrier line, depicting herself standing, alone, under a dark cloud and separated from her family who were placed on the other side of the barrier. Verbal reflection followed and the client used the symbol of the barrier to talk about her lived experience of depression.

> *Client: I feel like there's a barrier between my family and I and I'm under a dark cloud alone…..I think my depression is my barrier line. That's why I'm here. (lived reality)*

A second piece of music invited the client to imagine the clay scenario transformed in some way, however small the envisaged change may be. Client I reworked the clay image to represent the sun, her family reunited and a face depicting a smile. The two clay images starkly represent the contrast between lived reality and the expressed ideal.

As I witnessed the client reworking the clay I noticed that she used the clay barrier line to create the image of the clay sun. Rather than direct her away from the barrier line towards the sun, I suggested she reflect on the symbolism of using the barrier in order to create the sun.

> *Client: The barrier gone, the sun shines brighter, me and my baby's father and my baby, happy family. All happy in the future. (The expressed ideal)*
>
> Therapist: What's interesting for me is that you used the barrier to help to create the sun. What might that represent?
>
> *Client: It makes me stronger. The barrier makes me stronger. I can start dealing with it. If I go there, if I work through it, it can make me stronger.*
>
> Therapist: Sometimes the enemy can become the friend, the enemy can be embraced. Something about the sun containing the difficult stuff.
>
> What would it take to get from there (barrier) to here (the sun)?
>
> *Client: Break the barrier. Keep on breaking the barrier. Even if it's just 1mm at a time.*

The final step was an invitation to the client to reflect the symbol of the barrier through active music making. The client named the improvisation "Decimal breaking the barrier". The client led the improvisation on the conga drum, and as she played she provided a verbal account of the unfolding

musical narrative.

She concluded the improvisation by saying:

> *Client: not expecting too much of myself - remember Rome was not built in a day - so I can't expect to break all of the barrier in a short time –*
>
> Therapist: Ja that's right –
>
> *Client: I must give myself time*

This example from the data indicates how the combined creative act of music listening, image making, verbal reflection and music making, navigates a balance between being with the reality of the client's lived experience as the context for exploring new possibilities. Herein the client takes ownership of her process in such a way that she can integrate the envisaged change within her current reality and her personal terrain of therapy.

5.5.5. Activating the voice of agency

As demonstrated in this appraisal, the voice of the client gained prominence through the course of the music therapy intervention. Clients become collaborators and potential agents of transformation rather than passive recipients of expert intervention. Throughout the music therapy process clients were invited to access inner resources creativity, take the initiative, exercise choice, assume leadership roles and express thoughts and feelings openly.

Rolvsjord (2014) challenges the client-therapist binary which locates pathology, weakness and problems in the client, and strengths, expertise, solutions or cure in the therapist. In contrast, the client is regarded as competent, bringing to therapy resources and competencies as well as the complexity of struggling with the challenges of mental illness. Rolvsjord (2014) identifies four competencies which clients bring to the therapeutic relationship: 1) Musical competence; 2) theories of change; 3) reflexivity and agency in sessions of therapy; and 4) making use of therapy in everyday life.

Chapter 1 introduced the African concepts 'unbuntu' and 'batho pelé' which emphasise the humanity, personhood and independence of the client (van Staden, 2011). This worldview seeks not to elevate the individual but situates the individual within the communal placing importance on the interdependence

between the two. This research demonstrates the therapeutic relationship as modelling interdependence and support, a collaboration between client and therapist, in which the client was invited to act, to speak through words and music, to exercise autonomy and to be heard and received in a non- judgmental environment. The emerging voices presented at the beginning of this chapter highlight the manner in which the themes emanating from this research reflect the primacy and agency of the client within the music therapy process.

McCaffrey and Edwards (2016) conducted interviews with adult mental health service users to gain access to the perspective of clients who have received music therapy. Participants in the study referred to i) the rich sound world of music, ii) the humanity of music therapy and iii) the strengths enhancing opportunities experienced through music therapy (McCaffrey and Edwards, 2016:121). The emerging affordances from this research study resonate with these findings in that the rich sound world of music holds the extent of client experience, the humanity of music therapy is reflected through the verbal and musical voice of clients and strength enhancing opportunities were appropriated through musical processes which afforded experiences of inner strengthening and resilience.

5.5.6. Music therapy and the multi-disciplinary team

The emerging themes and affordances in the study highlight the potential role that music therapy can play within professional multi-disciplinary teams. These teams traditionally comprise a medical practitioner, psychologist, social worker, occupational therapist and nurse. The findings articulate the versatility of music therapy techniques in affording clients both verbal and non-verbal participation and expression. The content of the clients' experience in music therapy, in this study, is expressed through the 11 'emerging voices'. It is, thus, strongly recommended that the role of the respective music therapy techniques as well as the content and meaning of the voices of the particpants be fed back to members of the treating team, carers and families about their experience of and response to music therapy. This may advocate for the inclusion of music therapy in the treatment and management of these two disorders.

5.5.7. The final say

I conclude this section by allowing Client I (referred to in 5.5.4.) to speak the final word. Client I was diagnosed with major depressive disorder with a co-morbid diagnosis of conversion disorder which, in her case, manifested in the form of frozen speech. During my initial interview with client I as well as during session 1 she experienced great difficulty in physically speaking. Her words were slurred, inaudible and, at times, frozen. In later sessions she, particularly found it difficult to speak when anxious

or when confronted with painful emotional material. During the course of music therapy Client I gradually began to speak more fluently. At times non-verbal expressions of music and movement were used to replace speech, which seemed to offer her an alternate means of re-directing anxiety and stress. Towards the end of therapy, Client I would struggle with her speech only when articulating difficult aspects of her personal story, but would attempt to speak nonetheless. During one of the Receptive Music Therapy techniques she drew what she referred to as a 'whirlwind of emotions'. During that session she could write the emotions to which this referred, but was unable to speak what she had written. She had, however also written the words 'deep breath' on the same page as the whirlwind of emotion. She saw the deep breath as gaining some form of control within the chaos and speech freezing impact of the whirlwind. In future sessions she would physically stop if struggling to speak, take a deep breath and continue.

In our final session I suggested that she reflect on the 8-session music therapy process and that together we improvise a song based on her reflections. Of great significance, especially as the client had *not* found difficulty singing during the process, she asked me whether she could speak the words of the song while I played. This was extraordinary since the very thing she struggled most with was using her spoken voice to express herself. This she did, and she did so courageously and articulately. Client I's journey from a frozen to a fluent voice seems to be symbolic of her inner voice that similarly grew increasingly open and more willing to express itself.

Audio clip F illustrates a section of this song. The client is speaking while I support her on the guitar, singing the reflection of her spoken words.

Audio clip F (Track 26 – Finding her voice)

"Piece by piece it goes away, piece by piece it goes away. I'm closer to where I want to be, closer, the sun is shining brighter as the barrier breaks piece by piece, piece by piece, the barrier contributes to my sunshine, the barrier's no longer a barrier, but a step to my happiness, a step to my freedom, piece by piece, the barrier's now my friend. Step by step, it's built me up while I broke it down, it built me up while I broke it down, step by step, step by step, piece by piece step by step I grow"

Part B: Appraisal of the research process

In order for the voice of the client to emerge as it has, detailed and rigorous attention was required with regard to research design, sampling, planning and executing the clinical intervention, data preparation, transcription, analysis and reporting. What served this study well were the following research methodology decisions: i) to explore the said topic within individual music therapy rather than group music therapy; ii) the design of an eight week music therapy intervention affording sufficient time for clients to respond to a variety of music therapy techniques; iii) maintaining the session structure as uniformly as possible but with enough flexibility to respond to each client's engagement with the music therapy techniques; iv) to transcribe the sessions in a systematic manner, describing music sessions in their entirety, following the chronological sequence of sessions; v) focusing the analysis to three specific aspects of the transcribed sessions i.e. the detailed descriptions of the clients participation in active music making and the verbal responses to Active and Receptive Music Therapy techniques respectively;vi) to manually code the transcription rather than employ a computer software program. The nuance of the codes might have been lost using such, whereas it was essential to capture the essence of verbal and musical responses to accurate reflect the voice of the client, vii) to overtly state that the focus was not progress over time but rather on present moment affordances. The implication of this is that a phenomenon with one code was deemed of as much significance as a phenomenon illustrated by numerous codes and viii) the intention to describe the 'what' of clients' verbal and musical expressions rather than ascribe meaning or interpretation.

The following section further reflects upon the research process and offers commentary on possibilities for future research.

5.6. Research methodology appraisal

The methodology on which I report here, I appraise drawing on the usual consideration in qualitative research of trustworthiness in terms of a) credibility, b) applicability, c) consistency (Lincoln and Guba, 1985). In addition, I also apply the criteria of Stige et al. (2009) who propose an approach to qualitative research evaluation referred to through the acronym, EPICURE, which promotes reflexive dialogic evaluation rather than rules based judgement. The acronym refers to seven evaluation criteria: i) Engagement - the researcher's continuous interaction with and relationship to the phenomenon or

situation studied, ii) Processing - the process of producing, ordering, analyzing, and preserving empirical material, iii) Interpretation involves the act of creating meaning by identifying patterns and developing contexts for the understanding of experiences and descriptions, iv) Critique - the appraisal of merits and limits of research, v) Usefulness - value in relation to practical contexts, vi) Relevance in terms on interdisciplinary work and vii) Ethics - how values and moral principles are integrated in the actions and reflections of research (Stige at al, 2009 1508-1511).

The methodoloy of the study is supported by the strengths in terms of EPICURE as follows:

Engagement - The background to this research study was informed by the researcher's 13 years' experience as a clinical supervisor of music therapy interns in the field of adult mental health, as well as personal clinical experience in the field. Engagement in the research process included negotiating logistics and set-up at the identified hospital site, ongoing communication with the referring clinical team and hospital ward staff, conducting the music therapy intervention from the period February 2014 – December 2015. The engagement was substantive in being on an individualised basis, providing sufficient time for engagement (i.e., 8 sessions) and reciprocal engagement through both verbal and musical communicative means, and being driven with the pervasive therapeutic task to engage progressively. The engagement also provided much space for spontaneity in unforlding and developing of verbal, musical and interpersonal content.

Processing - Data were collected at one hospital site over a two year period. Every music therapy session was video recorded and transferred onto computer for analysis purposes. Sessions notes were written at the conclusion of sessions. Audio and edited video examples (to protect privacy) are included with the written text of findings to illustrate the emerging themes. Photographs of drawings, clay images and story texts were stored on computer for inclusion in the presentation of findings. Post therapy in-depth interviews were video recorded, stored and transcribed. As detailed in chapter 2, the video recordings of the sessions were transcribed and analysed in a detailed, systematic manner. The in-depth interviews were transcribed by the therapist researcher and analysed by an external researcher as detailed in chapter 2. Thematic analysis was applied in a systematic manner. No software program was used for the analysis of the data as it was deemed important that coding and analysis account all along for the context and emotional quality of client responses.

Interpretation - The choice of focus for this research grew out of a growing curiosity of the potential affordances of a mixed methods clinical approach in the field of adult mental health. The mixed methods approach, based on clinical techniques developed by the therapist-researcher, includes Active and Receptive Music Therapy techniques as well as musical and verbal work and forms the basis of the music therapy intervention at the heart of the research. Being well-acquainted with the clinical techniques and client group may be viewed as both advantageous and problematic. Advantageous, because the lens of experience is brought to the description and analysis of data, providing for empathic engagement and unfolding of more depth in experiences. Potentially problematic as familiarity with the subject matter potentially may tacitly undermine clarity with 'taken for granted' assumptions and knowledge. The fact that the researcher also acted as therapist-researcher during the clinical intervention brought her subjective experience of each client's process to the description and analysis of the data. It is never possible to separate oneself completely when assuming the dual role of therapist-researcher. This can potentially serve or skew the research process, depending on how it is managed. The therapist-researcher made every effort in the transcription and of clinical sessions and in-depth interviews as well as the analysis of the clinical data, to bracket personal, theoretical and clinical knowledge and assumptions. Triangulation (Lincolm and Guba. 1985), as detailed in chapter 2, was essential in maintaining rigour and managing subjectivity. Of paramount importance was the supervision collaboration throughout the process, but most particularly when identifying the emerging themes. In this way the themes were refracted through the inter-disciplinary lenses of psychiatry and music therapy respectively. In addition, as stated in 2.8, the audio examples were listened to by a music therapist external to the research process, and the post therapy interviews were analysed by an external researcher.

Critique - Considering the merits of the study, the 131 music therapy sessions provided ample material for qualitative analysis, more so than usually used in qualitative studies (Pope et al., 2000). Data saturation was reached insofar as numerous repeated codes emerged. There were however codes pertaining to just one phenomenon or just one client, which were deemed of significantimportance and included in the data analysis. Data saturation cannot be claimed for these, for each new client process holds the potential for the emergence of new content, which is congruent with the nature of knowledge acquisition in qualitative research as well as therapeutic processes that involve insatiable variety of experiences. It was deemed, nonetheless, that sufficient information had been generated from the data and that it was not necessary to increase the sample size. The study had stayed true to the proposed

sample size, of 20 participants. Whilst the transcription resulted in a large volume of data, the data were well organised, serving the analysis process efficiently.

The focus of this research was individual music therapy. Gold et al. 2009 highlight that there is a higher prevalence, in adult mental health literature, of group music therapy than individual music therapy research (Gold et al, 2009), meaning that this research contributes to the literature on individual therapy.

There is a limited body of literature that records and reflects service user experience of music therapy (McCaffrey and Edwards, 2016). This research contributes to the literature as client response was at the centre of this research, through the verbatim verbal responses of clients within the music therapy process and individual post therapy in-depth interviews.

This research is the first larger study of its kind in a public mental health facility in the South African context. Muirhead (2016, unpublished) conducted a pioneering smaller scale on the effect of short term group music therapy on negative symptoms with one group of forensic mental health patients at a public mental health facility in South Africa and vi) there is limited research using in-depth analysis of verbal and musical participation in music therapy with respect to the two diagnostic groups as represented in this study

Regarding limitations to the study, whilst the sample size and number of sessions were adequate for the research undertaken, a larger sample size might have either confirmed the existing emerging codes and themes, or may have elicited a broader range of emerging themes. As mentioned above, however, saturation may not to be attainable when the context is extended beyond given time and place.
Related to the context specific nature of qualitative research, this research was conducted at only one clinical site and findings may be different at another. The findings may have worth in other contexts insofar as the contexts are similar. One contextual specific was that this research focused intentionally on the public mental health sector. Within the South African context there can be disparity between qualitative contents as they would emerge in public and private mental health facilities respectively. In this sense, it is a limitation that there is no guarantee that the findings would be the same in the private sector. It may, however, also be seen as a strength to have findings that are specific to the public context without content relevant to the private sector being presumed as relevant to the public sector.

The clinical intervention was limited to eight sessions, which whilst appropriate for exposure to the music therapy techniques employed during this research, is a relatively brief time frame therapeutically given that longer term interventions are more appropriate for this sector of the adult mental health population. Therapy over a longer term period may reveal different content, but such is then also more likely to reflect therapeutic changes over time rather than being affordances attributed to specifically the music therapy techniques (as was the focus of this study). Even as it was, the affordances might have been partially influenced by patients recovering.

Usefulness – The music therapy intervention is easily replicated across similar adult mental contexts including the private sector, and could equally be adapted for adolescent mental health, as well as for a more diverse adult mental health population. Whilst the focus of this dissertation was not the techniques per se, but the musical and verbal affordances, the application of Active and Receptive Music Therapy techniques separately and in combination hold usefulness in clinical. The findings suggest that a blended music therapy approach holds efficacy for clinical work with both diagnostic groups but that the application of the techniques require scrutiny and careful conisderation in order to address the needs of indiviual clients, taking into consideration diagnostic features which may require the adaptation of certain techniques. The findings further indicate that working with symbolic material, musically, visually and verbally, holds value for both client groups but that the implementation and outcome of such techniques may differ. The findings highlight both musical and verbal affordances, acknowledging the role of verbal processing in music therapy, even with clients deemed more suitable for primarily music-centred work. Furthermore, thefindings propose an approach to therapy which acknowledges the complexity of disturbance and difficulty brought about by mental illness, whilst qually acknolwedging the resources within clients which hold potential for activation through such a blended methods approach.

Relevance – The interdisciplinary nature of this research renders the study relevant in contributing to knowledge in the fields of music therapy, psychiatry and the arts therapies in general. The study yields insight into music therapy practice specifically, clinical practice more generally and patient response with respect to the two diagnostic groups respectively. The findings hold relevance for music therapy as an inclusion in multi-disciplinary treatment programs within adult mental health settings. The findings demonstrate the efficacy of a blended methods music therapy intervention for the treatment of patients with major depressive disorder and schizophrenia-spectrum disorders. Music therapy as a

complementary treatment alongside standard care is relevant for clients for whom verbal processing may be difficult or inaccessible as Active Music Therapy holds communicative and self expressive possibilities for patients as a non verbal therapeutic modality. Equally a combination of Active and Receptive Music Therapy techniques in varying combinations hold value for clients to facilitate both non verbal and verbal forms of self expression. The findings serve as a guideline for reasons for referral to music therapy. Furthermore, the findings may serve as a guideline for music therapists in planning a treatment program for clients from either or both diagnostic with regard to formulation and implementation of music therapy techniques.

The study's relevance extends to advocacy for music therapy services in mental health care in the South African context. In addition, as Weskoppies Hospital is a training site for music therapy interns, the findings of this study may contribute to impacting the training and supervision of music therapy students in the field of clinical practice resources for work with adult mental health clients.

Ethics – Due protocol was followed in respect of gaining the necessary ethical clearance from the faculty of Health Sciences, University of Pretoria as well as Weskoppies Psychiatric Hospital, Pretoria. In a pre-therapy consultation session, the informed consent document was explained in detail with regard to the 8-session music therapy intervention, the post therapy in-depth individual interview and the fact that the music therapy sessions would be video recorded for transcription and analysis purposes. Only one participant declined to giveinformed consent owing to the fact that the sessions were to be video recorded. She, thus, did not participate in the study. Ethical considerations were extended to the transcription and presentation of the data. The transcribed sessions refer to Client A, B etc. and only audio recordings and 2 video recordings, edited in such a manner so as to conceal the identity of the participant, are included with the presentation of findings.

The appraisal of the research methodology will conclude with an evaluation of the trustworthiness of the study. To this end the three criteria of credibility, applicability and consistency will be considered (Lincoln and Guba, 1985).

The case study design was appropriate to meet the aims of this study. This idiographic approach characterises the individual case in order to develop a broader knowledge base from which transferability may be possible. (Aldridge, 1996; Aldridge, 2005). Consistency was adhered to

throughout the data collection phases with every effort taken to ensure that the same protocol was followed for each client i.e. consultation session, 8 music therapy sessions, adherence to structured session plan format, and a post therapy in-depth interview guided by a semi-structured interview schedule which was consistent across all clients.

The transcription of 131 sessions was approached in a systematic manner efficiently organising the data for ongoing analysis. There was consistency within the design pertaining to execution of the clinical intervention, data collection, preparation, transcription and analysis. The analysis of the post therapy in-depth interviews by an independent health practitioner, provide corroborative findings which support the findings of the music therapy process analysis. The inclusion of musical and visual data within the presentation of findings illustrate the written descriptions.

Whilst the findings of this study are not generalisable to the general population, the clinical techniques and emerging affordances may be applicable or transferable to other comparable adult mental health settings.

5.7. Recommendations for further research

As the reporting on this research study reaches its conclusion, it does so in a manner which is left asking more questions and acknowledging numerous future research possibilities given the limitations of this study.

Firstly, further research could be extended to include additional clinical sites in both public and private mental health care. These studies would serve to either support or point to important differences by virtue of contextual differences. Similarities in findings may point to more generalisable findings. Extending such qualitative research to other sites would contribute to a body of knowledge within South African mental health settings towards relevant music therapy practice;

Secondly, future research focusing on in-depth analysis of client response to Receptive Music Therapy techniques, with specific reference to symbolic material and imagery, the nature of the symbolic material, how symbols facilitate the telling of one's story and an examination of similarities and differences between diagnostic groups. Such research would elaborate upon and deepen the findings of

this research study and, as an extension, could include additional diagnostic groups such as other mood disorders and anxiety disorders;

Thirdly, the findings of this study focused on verbal and musical affordances as brought about by the two umbrella approaches of music therapy, i.e. Active and Receptive music therapy respectively. In order to develop a conceptual framework to determine best fit of technique to diagnostic features, in-depth anaysis of specific technqiues within each of the umbrella approaches and their musical and verbal affordances would assist in the develoment of treatment programs which would address the needs of specific dignostic groups;

Fourthly, considering the musical and verbal affordances which emerged from this research, with particular emphasis on the potential of the music therapy techniques to reveal unconscious material, future research which investigates the role of the respective and combined music therapy techniques for the purposes of assessment might contribute towards the development of a blended music therapy assessment protocol for adult mental health;

Fifthly, whilst the emphasis of this research was on individual music therapy, further research might explore, compare and describe the verbal and musical affordances of these Active and Receptive Music Therapy techniques within group music therapy settings across numerous public and private mental health settings. As limited financial and staffing resources can restrict access to additional forms of individual therapy, group music therapy may be more cost effective. Documented evidence which supports the efficacy of group music therapy as a complementary treatment for major depressive disorder and schizophrenia-spectrum psychotic disorders may offer service uses access to a different treatment modality.

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